

Utah WIC Program Formula and Food Authorization

Children at 12 Months of Age or Older and Women

Complete either formula amount (oz/d) OR RTF/Single Serving Product (cans/d)

If specific amount per day is not checked/indicated, then the formula cannot be provided.

A. Patient's Name: _____ Patient's DOB: _____	
Parent/Guardian Name: _____	
Primary Care Physician: _____ Discharging Physician: _____	
B. Medical Diagnosis – Check all that apply (must mark at least one)	
<input type="checkbox"/> Allergies <input type="checkbox"/> Weight-for-length/BMI \leq 5%ile <input type="checkbox"/> Feeding Difficulties <input type="checkbox"/> Prematurity <input type="checkbox"/> Cancer <input type="checkbox"/> BMI \leq 18.5 (18+yrs) <input type="checkbox"/> Malnutrition <input type="checkbox"/> Other ICD 10 Medical Dx: _____ <input type="checkbox"/> GERD <input type="checkbox"/> Inborn errors of metabolism <input type="checkbox"/> Chronic Renal Failure	
C. Name of Formula/Product:	
Physical Form of Formula:	<input type="checkbox"/> powder <input type="checkbox"/> ready to feed (RTF) <input type="checkbox"/> concentrated liquid
Formula Amount (oz/day):	<input type="checkbox"/> 8 <input type="checkbox"/> 16 <input type="checkbox"/> 24 <input type="checkbox"/> 27 <input type="checkbox"/> 29 <input type="checkbox"/> Other: _____ oz/day (no ranges) <small>The maximum allowance is 30 oz/day for a 30-day month and 29 oz/day for 31-day month.</small>
RTF/Single Serving Product (cans/day):	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 3.5 <input type="checkbox"/> Other: _____
D. WIC Supplemental Foods – Age-appropriate foods will be issued if nothing is marked.	
<input type="checkbox"/> No milk <input type="checkbox"/> No wheat bread/brown rice/tortillas/pasta <input type="checkbox"/> No cereal <input type="checkbox"/> No cheese <input type="checkbox"/> No dry beans/canned beans <input type="checkbox"/> No juice <input type="checkbox"/> No yogurt <input type="checkbox"/> No canned fish <input type="checkbox"/> No fruits/vegetables <input type="checkbox"/> No eggs <input type="checkbox"/> No peanut butter	
E. Whole Milk/Other	Please indicate medical reason/qualifying condition if prescribing whole milk. Note: Personal preference is not a qualifying condition.
<input type="checkbox"/> *Allow whole milk for a child \geq 2 years or a woman. *WIC participant must have a medical condition, requiring a medical formula, to receive whole milk. Medical reason: _____ <input type="checkbox"/> For children, allow jarred infant fruits and vegetables. <input type="checkbox"/> Substitute infant cereal for breakfast cereal.	Skim, 1%, 2% Milk for a 12-23 month-old with weight \geq 85th %: <input type="checkbox"/> Skim / 1% milk <input type="checkbox"/> 2% milk
F. Months of Issuance (6 months will be issued including current month if nothing is marked)	<input type="checkbox"/> 2 mo. <input type="checkbox"/> 4 mo. <input type="checkbox"/> 6 mo. <input type="checkbox"/> 8 mo. <input type="checkbox"/> 10 mo. <input type="checkbox"/> 12 mo. *Order will continue through the end of the expired month.
G. Health Care Provider Information (A written or stamped signature is acceptable.)	
State Licensed Prescriptive Authority: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> CNM	
Signature: _____ Date: _____	
Clinic/Hospital: _____ Phone: _____ Fax: _____	
WIC USE ONLY	
FID:	Approved by: _____
	Received in Clinic Date: _____ FAFAP Expiration Date: _____

Instructions to Complete Utah WIC Formula and Food Authorization Form Children at 12 Months of Age or Older and Women

Step A: Complete patient information.

Step B: Indicate all medical diagnoses that apply to patient. If diagnosis is not listed, please write in the ICD 10 Medical Diagnosis that applies. If the patient is on Medicaid and meets requirements, Medicaid should be the primary provider of the needed formula/product.

Step C: Formula/Product

- List name and brand of formula required.
Authorization should be based on medical need and not patient preference.
- Specify if the requested formula is powder, concentrated liquid, or ready to feed.
- Indicate quantity of authorized food or formula needed per day. Please give specific amount needed -no ranges can be accepted.

NOTE: Breastfeeding mothers may request less.

Step D: Please indicate if WIC supplemental foods are allowed or if there are any restrictions. Full provision of WIC food packages are listed below.

Step E: WIC can only give clients ≥ 2 years of age whole milk if they are receiving a medical specialty formula and require additional calories.

Step F: Specify the length of time this formula and food authorization will be valid.

Step G: Health Care Provider Information must be signed by a Utah state licensed prescriptive authority.

Full Provision of WIC Foods*	
Children and Women	
<ul style="list-style-type: none"> • Eggs - 1 dozen/month • Fruits/Vegetables - \$25 - \$49 • Cereal - 36 oz/month • Milk - up to 4 gal/month (Children approximately 13 -17 oz/day) 	<ul style="list-style-type: none"> • Juice - 1 gal/month (Children approximately 4 oz/day) • Whole Grains - 1-2 lbs/month • Beans - 1 lb/month • Peanut Butter - 16 - 18 oz/month
<p>*If formula is needed, the maximum allowance is 30 oz/day for a 30-day month and 29 oz/day for a 31-day month or no more than 910 oz per month.</p>	