



ARKANSAS DEPARTMENT OF HEALTH
WIC PROGRAM
SPECIAL FORMULA REQUEST

WIC may provide the following formulas with documented medical reason/diagnosis. Supplemental foods will only be issued with approval of a physician, physician assistant with prescriptive authority or advanced practice registered nurse with prescriptive authority. All prescriptions are reviewed by a WIC Registered Dietitian.

Name of Infant/Child _____ Date of Birth _____

Height/Length _____ Weight _____ Date Taken _____

Note: Ready-to-Use formula can be issued if the caretaker is physically or mentally unable to prepare formula or if water supply is unsafe.

TO REQUEST A SPECIAL FORMULA:

1. Review the descriptions for use.
2. Check selected formula listed below or on back.
3. Write in diagnosis.
4. Circle number of months prescribed.
5. Indicate the amount needed **per day**.
6. Select supplemental foods to be restricted.
7. Complete date and sign* on back.

**signature must be from MD, PA, APRN, or DO with prescriptive authority*

Note: Special exempt formula may only be provided for a **maximum period of three months**. **Exceptions** which may warrant longer approval period **up to six months** are: tube feeding, PKU, galactosemia, cystic fibrosis, short bowel syndrome, fatty acid oxidation disorders (FAOD), diagnosed cow's milk allergy (CMA), specified malabsorption, preterm infants discharged on a preterm transitional formula, palliative care, conditions requiring the use of Similac PM 60/40.

| Formula | Descriptions for Use | Diagnosis | Duration & Amount |
|--|--|-----------|--|
| <input type="checkbox"/> Alimentum—Abbott | Allergy to milk and/or soy protein; severe malnutrition; chronic diarrhea, short bowel syndrome; known or suspected corn allergy | | 1, 2, 3, 4, 5, 6 month(s) _____oz/day |
| <input type="checkbox"/> Neocate Infant DHA & ARA*—Nutricia <input type="checkbox"/> Neocate Jr. with Prebiotics*—Nutricia <input type="checkbox"/> Unflavored <input type="checkbox"/> Vanilla | Allergy to intact protein and casein hydrolysates; severe food allergies; short bowel syndrome; malabsorption <i>Neocate Jr. is intended for children over the age of one; standard dilution is 30 calories per ounce</i> | | 1, 2, 3, 4, 5, 6 month(s) _____oz/day |
| <input type="checkbox"/> Enfacare—Mead Johnson | Preterm infant transitional formula for use between premature formula and term formula; must have minimum weight of 1800 grams or 4 pounds. Not approved for an infant previously on term formula or a term infant for increased calories. | | 1, 2, 3, 4, 5, 6 month(s) _____oz/day |
| <input type="checkbox"/> Nutramigen Enflora LGG*—Mead Johnson <input type="checkbox"/> Nutramigen DHA & ARA—Mead Johnson (RTU or concentrate only) | Milk or soy allergy; other food allergies; sensitivity to intact protein; chronic diarrhea; GI bleeds <i>Note: Powdered Nutramigen Enflora LGG may be used for galactosemia</i> | | 1, 2, 3, 4, 5, 6 month(s) _____oz/day |
| <input type="checkbox"/> Portagen*—Mead Johnson | Pancreatic insufficiency, bile acid deficiency or lymphatic anomalies; biliary atresia; liver disease; chylothorax | | 1, 2, 3, 4, 5, 6 month(s) _____oz/day |
| <input type="checkbox"/> Pregestimil—Mead Johnson | Fat malabsorption and sensitivity to intact proteins; cystic fibrosis; short bowel syndrome; intractable diarrhea; severe protein calorie malabsorption | | 1, 2, 3, 4, 5, 6 month(s) _____oz/day |
| <input type="checkbox"/> PKU Periflex Early Years*—Nutricia <input type="checkbox"/> PKU Periflex Junior Plus*—Nutricia | PKU; Hyperphenylalaninemia <i>Periflex Infant for infants</i> <i>Periflex Junior for toddlers and children</i> | | 1, 2, 3, 4, 5, 6 month(s) _____oz/day |
| <input type="checkbox"/> Similac PM 60/40*—Abbott | Renal, cardiac or other condition that requires lowered minerals | | 1, 2, 3, 4, 5, 6 month(s) _____oz/day |
| <input type="checkbox"/> Gerber Good Start Premature 24—Gerber | Preterm, low birthweight infants; not intended for use after a weight of 8 pounds is reached. Not approved for an infant previously on term formula or a term infant for increased calories | | 1, 2, 3 month(s) _____oz/day |

* Indicates formula is available in powder only
WIC-51 (R 3/16)

Name of Infant/Child _____

Date of Birth _____

| Formula | Descriptions for Use | Diagnosis | Duration & Amount |
|--|--|-----------|--|
| Oral Supplements (1-5 years of age) <input type="checkbox"/> Boost Kids Essential —Nestle <input type="checkbox"/> Nutren Junior 1.0 with Fiber —Nestle | Oral motor feeding disorders; FTT from underlying medical condition that increases calorie requirements beyond what is expected FTT must be indicated by one or more of the following: <ul style="list-style-type: none"> • Weight consistently below the 3rd percentile for age; • Weight less than 80% of ideal weight for height/age; • Progressive fall-off in weight to below the 3rd percentile; or • A decrease in expected rate of growth along the child's previously defined growth curve irrespective of its relationship to the 3rd percentile | | 1, 2, 3, 4, 5, 6 month(s) _____oz/day |
| Tube Feeding (1-5 years of age) <i>Note: may prescribe for 6 months duration.</i> <input type="checkbox"/> Nutren Junior 1.0 —Nestle <input type="checkbox"/> Nutren Junior 1.0 with Fiber —Nestle <input type="checkbox"/> Boost Kids Essential —Nestle | Tube feedings; oral motor feeding disorders; medical conditions that increase caloric needs | | 1, 2, 3, 4, 5, 6 month(s) _____oz/day |

* Indicates formula is available in powder only

Supplemental Foods

The participant will receive the supplemental foods listed below, appropriate to their WIC participant category, in addition to the WIC formula. Please indicate any supplemental foods or restrictions **not approved** due to contraindications with the participant's medical diagnosis.

| WIC Participant Category | WIC Supplemental Foods Available | Do Not Give | Restrictions/Comments |
|--------------------------|----------------------------------|-------------|-----------------------|
| Infants (6-12 months) | Infant Cereal | | |
| | Infant Vegetables/Fruits | | |
| Children and Women | Milk | | |
| | Cheese | | |
| | Cereal | | |
| | Juice | | |
| | Eggs | | |
| | Vegetables/Fruits | | |
| | Whole Grains | | |
| | Beans | | |
| | Peanut Butter* | | |
| | Canned Fish** | | |

* Peanut butter will not be issued to children under 2 years of age.

** Exclusively Breastfeeding Women, Partially Breastfeeding Women of Multiples or Pregnant Woman with Multiples are the only WIC participant categories eligible to receive canned fish.

Date: _____ Medical Provider (Print): _____ Contact Phone Number: (____) _____

Medical Provider Signature: _____
 MD PA APRN DO
(discipline of medical provider must be indicated)

LHU/WIC CLINIC USE ONLY:

Request received by: _____ Title: _____ Date: _____

CPA reviewing request: _____ Title: _____ Date: _____