

## Arkansas WIC Program Special Formula Request

WIC may provide the following formulas with documented medical reason/diagnosis for up to 3 months. Supplemental foods will only be issued with approval of a physician or advanced practice 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 \_\_\_\_\_

List history of formulas previously tried and resulting symptoms: \_\_\_\_\_

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. Circle 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.

Formula	Descriptions for Use	Diagnosis	Duration & Amount
Nutramigen Enflora LGG*—Mead Johnson	Sensitivity or allergy to milk and/or soy protein; chronic diarrhea, food allergies, GI bleeds; Note: Need to have tried <u>Gentlease LIPIL</u>		1, 2, or 3 month(s) _____oz/day
Nutramigen LIPIL—Mead Johnson <i>Concentrate or RTU forms only—must meet policy requirements to receive</i>	Sensitivity or allergy to milk and/or soy protein; chronic diarrhea, food allergies, GI bleeds; Note: Need to have tried <u>Gentlease LIPIL</u>		1, 2, or 3 month(s) _____oz/day
Pregestimil LIPIL—Mead Johnson	Allergy to milk and/or soy protein; chronic diarrhea; short gut; cystic fibrosis; fat malabsorption due to GI or liver disease		1, 2, or 3 month(s) _____oz/day
Alimentum—Abbott	Allergy to milk and/or soy protein; severe malnutrition; chronic diarrhea, short bowel syndrome; known or suspected corn allergy Note: Need to have tried <u>Gentlease LIPIL</u>		1, 2, or 3 month(s) _____oz/day
<input type="checkbox"/> EleCare*—Abbott <input type="checkbox"/> Neocate*—Nutricia <input type="checkbox"/> Nutramigen AA LIPIL*—Mead Johnson	Allergy to intact protein and casein hydrolysates; severe food allergies; short bowel syndrome; malabsorption; Note: Need to have tried <u>Alimentum</u> , <u>Nutramigen LIPIL</u> , or <u>Pregestimil LIPIL</u>		1, 2, or 3 month(s) _____oz/day
Portagen*—Mead Johnson	Pancreatic insufficiency, bile acid deficiency or lymphatic anomalies. biliary atresia; liver disease; chylothorax		1, 2, or 3 month(s) _____oz/day
Similac PM 60/40—Abbott <b>Note: may prescribe for 6 months duration</b>	Renal, cardiac or other condition that requires lowered minerals		1, 2, 3, 4, 5, 6 month(s) _____oz/day
<input type="checkbox"/> Phenyl-Free 1*—Mead Johnson <input type="checkbox"/> Phenex I*—Abbott <input type="checkbox"/> Phenyl-Free 2*—Mead Johnson <input type="checkbox"/> Phenex II*—Abbott <b>Note: may prescribe for 6 months duration</b>	PKU; Hyperphenylalaninemia  <i>Phenyl-Free 1 and Phenex I for infants and toddlers</i>  <i>Phenyl-Free 2 and Phenex II for children and adults</i>		1, 2,3,4,5, 6 month(s) _____oz/day

\*indicates formula is available in powder only

Formula	Descriptions for Use	Diagnosis	Length of Request
<input type="checkbox"/> Enfamil Premature LIPIL—Mead Johnson (20 calories) <input type="checkbox"/> Enfamil Premature LIPIL—Mead Johnson (24 calories)	Preterm, low birthweight baby to 44 weeks gestational age or to a maximum weight of 8 pounds-Not approved for an infant previously on term formula or a term infant for increased calories		1, 2, or 3 month(s) _____oz/day
EnfaCare LIPIL—Mead Johnson	Preterm infant transitional formula-for use between premature formula and term formula Note: must have minimum weight of 1800 grams (4 lbs)-- Not approved for an infant previously on term formula or a term infant for increased calories		1, 2, or 3 month(s) _____oz/day
Oral Supplements (1-5 years of age) <input type="checkbox"/> PediaSure—Abbott <input type="checkbox"/> PediaSure with Fiber—Abbott	Oral motor feeding disorders; FTT from underlying medical condition that increases calorie requirements beyond what is expected		1, 2, or 3 month(s) _____oz/day
Tube Feeding (1-5 years of age) <i>Note: may prescribe for 6 months duration</i> <input type="checkbox"/> PediaSure Enteral—Abbott <input type="checkbox"/> PediaSure Enteral with Fiber—Abbott	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 Number: _____
Medical Provider Signature: _____		Prescriptive Authority Number: _____ (APN nurses with prescriptive authority only)