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 protein allergy (CMPA), 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
Gerber Extensive HA* —Gerber	Allergy and/or intolerance to cow's milk protein.		1, 2, 3, 4, 5, 6 month(s) _____oz/day
Nutramigen Enflora LGG* —Mead Johnson Nutramigen DHA & ARA —Mead Johnson (RTU or concentrate only)	Allergy to milk and/or soy protein; other food allergies; sensitivity to intact protein; chronic diarrhea; GI bleeds. *Note: Powdered Nutramigen Enflora LGG may be used for galactosemia.*		1, 2, 3, 4, 5, 6 month(s) _____oz/day
Alfamino Infant* —Nestle Alfamino Junior* —Nestle	Allergy to cow's milk protein; multiple food allergies; eosinophilic GI disorders; malabsorptive conditions, short bowel syndrome. *Alfamino Jr is intended for children over the age of one; standard dilution is 30 calories per ounce.*		1, 2, 3, 4, 5, 6 month(s) _____oz/day
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
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
PKU Periflex Early Years* —Nutricia PKU Periflex Junior Plus* —Nutricia	PKU; Hyperphenylalaninemia. *Periflex Early Years for infants* *Periflex Junior for toddlers and children*		1, 2, 3, 4, 5, 6 month(s) _____oz/day
Similac PM 60/40* —Abbott	Renal, cardiac or other condition that requires lowered minerals.		1, 2, 3, 4, 5, 6 month(s) _____oz/day
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

* Indicates formula is available in powder only

Name of Infant/Child_____ Date of Birth_____

Formula	Descriptions for Use	Diagnosis	Duration & Amount
Alimentum —Abbott (RTU only)	Allergy to milk and/or soy protein; severe malnutrition; chronic diarrhea, short bowel syndrome; known or suspected corn allergy. *Ready-to-Use is indicated for infants with known or suspected corn allergy, unsanitary or restricted water supply, caregiver with difficulty diluting powder formula.*		1, 2, 3, 4, 5, 6 month(s) _____oz/day
Oral Supplements (1-5 years of age) Boost Kids Essential —Nestle Nutren Junior 1.0 with Fiber —Nestle	Oral motor feeding disorders; FTT from underlying medical conditions that increase caloric needs. FTT indicators that a physician might use for diagnosis include: • 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) *Note: may prescribe for 6 months duration.* Nutren Junior 1.0 —Nestle Nutren Junior 1.0 with Fiber —Nestle 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:_____