For medical formula/foods, complete section A.
For a 19 calorie infant formula, complete section B.
For all patients, if applicable, complete section C.
For a soy-based beverage for children, complete section D.

West Virginia WIC Program

Prescription Formula Form

For Prescribed Formulas and Foods

Please fax form to WIC clinic or have WIC participant return form to clinic.

Patient Information

Patient's Full Name: | **DOB:**

Caregiver's name:

A. Medical Formula/Medical Foods

Medical Reason/Diagnosis: | **ICD Code:**

Formula requested: | **Prescribed amount:** _______ **oz/day**

Prescribed Form: ☐ Powder ☐ Concentrate ☐ Ready-to-feed

Time needed: ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

B. 19 Calorie Infant Formula (Similac Sensitive [not available in concentrate form], Similac for Spit-Up, or Similac Total Comfort)

Medical Reason/Diagnosis: | **ICD Code:**

Formula requested: | **Prescribed amount:** _______ **oz/day**

Prescribed Form: ☐ Powder ☐ Concentrate ☐ Ready-to-feed

Time needed: ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

C. Supplemental Foods

In addition to the infant formula/medical food, supplemental foods appropriate to the WIC participant category will be provided. Please mark the appropriate boxes below to indicate any foods that would be contraindicated with the patient's medical diagnosis.

☐ **No supplemental foods at this time:** omit all supplemental foods and provide formula/medical food ONLY.

WIC Participant Category	WIC Supplemental Foods Available	Do Not Give	Restrictions / Special Instructions
Infants 6-11 months	Infant cereal		
	Infant fruits/vegetables		
Children -and- **Women**	Milk		
	Cheese		
	Eggs		
	Juice		
	Breakfast cereals		
	Legumes and/or peanut butter		
	Fruits and vegetables		
	Whole grains		
	Fish (exclusively breastfeeding women only)		

D. Soy-based Beverage for Children

Mark the qualifying condition that justifies the need for soy beverage as a milk substitute:
☐ Milk allergy ☐ Severe lactose intolerance ☐ Vegan diet ☐ Other (specify) ______________________

E. Health care provider information

Provider's name (please print): ☐ **MD** ☐ **PA** ☐ **DO** ☐ **NP**

Medical office/clinic:

Phone #: | **Fax#:** | **Date:**

Signature of health care provider:

WIC USE ONLY | **Approved by:** | **Date:**