Arizona WIC Special Formula Authorization Form

Children, Women and Healthy Infants

Client Name: ____________________

Date of Birth: ____________________ WIC Client ID: ____________________

Please fully complete every section (1-7) to avoid delays in issuance. Please choose WIC rebated formulas whenever possible, as noted by '*'.

1. Formula(s) Previously Tried:

WIC contract formula:

- ☐ Similac Advance*
- ☐ Similac Sensitive*
- ☐ Similac for Spit-up*
- ☐ Similac Total Comfort*
- ☐ Enfamil ProSobee*
- ☐ **Other:** ____________________

2. Current Formula Request:

- ☐ Similac Advance*
- ☐ Similac Sensitive*
- ☐ Similac for Spit-up*
- ☐ Similac Total Comfort*
- ☐ Enfamil ProSobee*
- ☐ Enfagrow Toddler Transitions Soy*
- ☐ Alimentum
- ☐ Nutramigen
- ☐ Pediasure (must meet WIC criteria for issuance
- ☐ **Other:** ____________________

Form of Formula: ☐ Powder ☐ Concentrate ☐ Ready-to-feed

3. Amount of Formula Requested Per Day:

☐ Oral ☐ Tube Feeding ____________________

4. Diagnosis for routine formula (includes Similac Advance, Similac Sensitive, Similac for Spit-up, Enfamil ProSobee, and Similac Total Comfort):

☐ Formula Intolerance ☐ Food allergy ☐ Inappropriate growth patterns ☐ Other:

Diagnosis for Special Formula or Medical Food:

☐ Prematurity ☐ GERD or reflux ☐ Dysphagia ☐ Failure to thrive (<5th percentile wt/length or BMI/age)

☐ Severe food allergy ☐ Other: ____________________

Note: Must be a specific medical diagnosis.

5. WIC Foods: *Please check any foods listed below that are **NOT** appropriate for the diagnosis.*

Note: Infant <6 mo will not receive foods.

☐ All foods are appropriate for the client once 6 months old. ***OR***

Category	WIC Foods	Do Not Give
Infants (6-11 mo.)	**Infant cereal**	☐
	Infant Jarred-fruits/vegetables	☐
Children (1-5 yr.) and Women	**Cow's milk**	☐
	Cheese	☐
	Eggs	☐
	Peanut butter	☐
	Whole grains**	☐
	Cereal	☐
	Beans	☐
	Vegetables/fruits	☐
	Juice	☐
	Soy milk	☐
	Tofu	☐

Category	WIC Foods	Do Not Give
Exclusively Nursing Women	**Canned Fish**	☐

Comments: ____________________

***Grains include the options of whole wheat bread, brown rice, and/or corn tortillas.*

6. Length of Time Requested: ☐ Up to first birthday **OR** # months: __________ **OR** # weeks: __________

7. Print Provider Name/Title: ____________________ **Date:** __________

Healthcare Provider Signature: ____________________ **Phone Number:** __________

Local Nutritionist/State Approval

☐ Approved ☐ Not Approved Length of Authorization: From __________ To __________

Comments: ____________________

Signature: ____________________

Please visit http://www.azwic.gov/physicians.htm for additional forms or information. Revised 2/2014