

# Utah WIC Program Formula and Food Authorization Infants up to 12 Months of Age

Please complete each appropriate section below or formula/foods cannot be issued.

A. Patient's Name: _____ Patient's DOB: _____	
Parent/Guardian Name: _____ Today's Date: _____	
Primary Care Physician : _____ Discharging Physician: _____	
<b>B. Medical Diagnosis</b> – Check all that apply	
<input type="checkbox"/> Allergies <input type="checkbox"/> GERD <input type="checkbox"/> Feeding Difficulties <input type="checkbox"/> Prematurity <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> FTT <input type="checkbox"/> Malnutrition <input type="checkbox"/> Other ICD 10 Medical Dx: _____	
<b>C. Name of Formula/Product:</b> _____	
Physical Form of Formula: <input type="checkbox"/> powder <input type="checkbox"/> concentrated liquid <input type="checkbox"/> ready to feed (RTF)	
Partially Breastfed Infant Formula Amount (oz/day): <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 9 <input type="checkbox"/> 12 <input type="checkbox"/> Other: _____ oz/day (no ranges)	
Fully Formula Fed Infant Formula Amount (oz/day): <input type="checkbox"/> 20 <input type="checkbox"/> 24 <input type="checkbox"/> 27 <input type="checkbox"/> 29 <input type="checkbox"/> Other: _____ oz/day (no ranges) <input type="checkbox"/> Full WIC Formula Provision (Issued if nothing is marked)	
<b>D. WIC Infant Foods</b>	
From 6 months until one year of age, WIC infant foods are available in addition to the prescribed formula. <b>If nothing is marked, all foods will be issued.</b>	
<input type="checkbox"/> No infant cereal <input type="checkbox"/> No infant fruits and infant vegetables	
<b>E. Months of Issuance</b>	
(6 months will be issued including current month if nothing is marked)	
<input type="checkbox"/> 1 mo. <input type="checkbox"/> 2 mo. <input type="checkbox"/> 3 mo. <input type="checkbox"/> 4 mo. <input type="checkbox"/> 5 mo. <input type="checkbox"/> 6 mo.	
<b>Order will continue through the end of the expired month.</b>	
**See reverse for exceptions	
<b>F. Health Care Provider Information</b> (A written or stamped signature is acceptable.)	
State Licensed Prescriptive Authority <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA	
Signature _____ Clinic/Hospital _____	
Fax# _____ Phone # _____	
<b>WIC USE ONLY</b>	Approved by: _____
	Received in Clinic Date: _____ FAFAF Expiration Date: _____



UTAH | WOMEN, INFANTS & CHILDREN

**Instructions to Complete  
Utah WIC**

**Formula and Food Authorization Form**  
**Infants up to 12 Months of Age**

**Step A:** Complete patient information.

**Step B:** Indicate all medical diagnoses that apply to patient. If diagnosis is not listed, please write in the ICD 10 Medical Diagnosis that applies.

**Step C:** Formula/Product

**NOTE:** Please see list of WIC contract formulas that do not require this authorization for infants < 12 months.

- List name and brand of formula required.  
**Authorization should be based on medical need and not patient preference.**
- Specify if the requested formula is powder, concentrated liquid, or ready to feed.
- Indicate quantity of authorized food or formula needed per day. **The full WIC formula and food provision (see table below) will be issued unless other instructions are noted.** Please give specific amount needed - no ranges can be accepted.  
 NOTE: Breastfeeding mothers may request less than the full WIC formula provision to supplement their breast milk.

**Step D:** Please indicate if WIC Complementary Foods are allowed or if there are any restrictions. For infants, foods are given at ≥ 6 months of age. **Infant meats are only available for fully breastfeeding infants.** (Full provision of WIC food packages are listed below.)

**Step E:** Specify the length of time this formula and food authorization will be valid.  
 \*\*Pharmacy-ordered premature formulas must be requested monthly.

**Step F:** Health Care Provider Information must be signed by a Utah state licensed prescriptive authority.

**Utah WIC Rebate Formulas**

**Issuing the following contract formula doesn't require the use of this form and will be more cost effective allowing the Utah WIC Program to serve more participants**

Similac Advance

Gerber Good Start Soy

Gerber Graduates Soy

**The following formulas must be ordered by the health care provider, using this form, and will still result in a rebate**

Similac Sensitive

Similac for Spit Up

Similac Total Comfort

**Full Provision of WIC Formula and Food\***

**Infants**

**0-3 months of age:**

- 28/29 oz formula/day

**4-5 months of age:**

- 30/32 oz formula/day

**6-11 months of age:**

- 22/23 oz formula/day,
- 24 oz infant cereal/month,
- 32 jars (4 oz. size) of infant food fruits/vegetables/month

\*Amounts based off of 30/31 day months

# Utah WIC Program Formula and Food Authorization

## Children at 12 Months of Age or Older and Women

Please complete each appropriate section below or formula/foods cannot be issued.

<b>A. Patient's Name:</b> _____ <b>Patient's DOB:</b> _____ <b>Parent/Guardian Name:</b> _____ <b>Today's Date:</b> _____ <b>Primary Care Physician :</b> _____ <b>Discharging Physician:</b> _____	
<b>B. Medical Diagnosis</b> – Check all that apply <input type="checkbox"/> Allergies <input type="checkbox"/> GERD <input type="checkbox"/> Feeding Difficulties <input type="checkbox"/> Prematurity <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> FTT <input type="checkbox"/> Malnutrition <input type="checkbox"/> Other ICD 10 Medical Dx: _____	
<b>C. Name of Formula/Product:</b> _____	
<b>Physical Form of Formula:</b> <input type="checkbox"/> powder <input type="checkbox"/> concentrated liquid <input type="checkbox"/> ready to feed (RTF)	
<b>Formula Amount (oz/day):</b> <input type="checkbox"/> 24 <input type="checkbox"/> 27 <input type="checkbox"/> 29 <input type="checkbox"/> Other: _____ oz/day (no ranges)	
<b>RTF/Single Serving Product (cans/day):</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 3.5 <input type="checkbox"/> Full WIC Formula Provision (issued if nothing is marked)	
<b>D. WIC Supplemental Foods</b> – Age appropriate foods will be issued if nothing is marked. <input type="checkbox"/> No milk <input type="checkbox"/> No wheat bread/brown rice/tortillas/pasta <input type="checkbox"/> No cereal <input type="checkbox"/> No cheese <input type="checkbox"/> No dry beans/canned beans <input type="checkbox"/> No juice <input type="checkbox"/> No yogurt <input type="checkbox"/> No canned fish <input type="checkbox"/> No fresh fruits/vegetables <input type="checkbox"/> No eggs <input type="checkbox"/> No peanut butter	
<b>E. Whole Milk</b> Please indicate medical reason/qualifying condition if prescribing whole milk. <span style="background-color: yellow; font-weight: bold;">Note: Personal preference is not a qualifying condition.</span>	
<input type="checkbox"/> Allow whole milk for a child $\geq$ 2 years or a woman. WIC participant must have a medical condition, requiring a medical formula, to receive whole milk.	<b>Medical Reason/Qualifying Condition:</b> _____
<b>F. Months of Issuance</b> (6 months will be issued including current month if nothing is marked)	<input type="checkbox"/> 1 mo. <input type="checkbox"/> 2 mo. <input type="checkbox"/> 3 mo. <input type="checkbox"/> 4 mo. <input type="checkbox"/> 5 mo. <input type="checkbox"/> 6 mo. <span style="background-color: yellow; font-weight: bold;">Order will continue through the end of the expired month.</span>
<b>G. Health Care Provider Information</b> (A written or stamped signature is acceptable.)	
State Licensed Prescriptive Authority <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA Signature _____ Clinic/Hospital _____ Fax# _____ Phone # _____	
<b>WIC USE ONLY</b>	Approved by: _____ Received in Clinic Date: _____ FAFAF Expiration Date: _____

# Instructions to Complete Utah WIC Formula and Food Authorization Form Children at 12 Months of Age or Older and Women

**Step A:** Complete patient information.

**Step B:** Indicate all medical diagnoses that apply to patient. If diagnosis is not listed, please write in the ICD 10 Medical Diagnosis that applies.

**Step C:** Formula/Product

- List name and brand of formula required.  
**Authorization should be based on medical need and not patient preference.**
- Specify if the requested formula is powder, concentrated liquid, or ready to feed.
- Indicate quantity of authorized food or formula needed per day. **The full WIC provision (see table below) will be issued unless other instructions are noted.** Please give specific amount needed -no ranges can be accepted.  
NOTE: Breastfeeding mothers may request less than the full WIC provision to supplement their breast milk.

**Step D:** Please indicate if WIC supplemental foods are allowed or if there are any restrictions. Full provision of WIC food packages are listed below.

**Step E:** WIC can only give clients  $\geq 2$  years of age whole milk if they are receiving a medical specialty formula and require additional calories.

**Step F:** Specify the length of time this formula and food authorization will be valid.

**Step G:** Health Care Provider Information must be signed by a Utah state licensed prescriptive authority.

<b>Full Provision of WIC Foods*</b>	
<b>Children and Women</b>	
<ul style="list-style-type: none"> <li>• <b>Eggs</b> - 1 dozen/month</li> <li>• <b>Fruits/Vegetables</b> - \$8-\$10</li> <li>• <b>Cereal</b> - 36 oz/month</li> <li>• <b>Milk</b> - up to 4 gal/month (Children approximately 13 -17 oz/day)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Juice</b> - 1 gal/month (Children approximately 4 oz/day)</li> <li>• <b>Whole Grains</b> - 1-2 lbs/month</li> <li>• <b>Beans</b> - 1 lb/month</li> <li>• <b>Peanut Butter</b> - 18 oz/month</li> </ul>
<b>*If formula is needed, maximum allowance 29-30 oz/day based on number of days in month.</b>	

