MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
WIC AND NUTRITION SERVICES

MEDICAL DOCUMENTATION - HEALTH CARE PROVIDER AUTHORIZATION FOR SPECIAL FORMULAS AND WIC SUPPLEMENTAL FOOD

Reset Form

Important! Medical documentation is federally required to issue special formula(s) and some supplemental foods to WIC women, infants and children who have qualifying condition(s) that require(s) the use of special formula(s) listed on the back of this form. The use of conventional foods may be precluded, restricted, or inadequate to address their special nutritional needs. The Missouri WIC Program does **NOT** authorize issuance of special formulas for:

1) Non-specific symptoms such as intolerance, fussiness, gas, spitting up, constipation, or colic; OR
2) Enhancing nutrient intake or managing body weight without an underlying medical condition.

Important!
Fax form to the WIC clinic.
***or* have WIC participant return form to the WIC clinic.**

A. PARTICIPANT INFORMATION

PARTICIPANT'S NAME:			DOB:
PARENT/CAREGIVER'S NAME:	HEIGHT:	WEIGHT:	HGB:

Medical Reason/DX: (Qualifying Condition) RF = Missouri WIC Risk Factor			
	☐ Low Birth Weight (RF 141)	☐ Metabolic Disorders (RF 351) *Describe the disorder in box below.*	☐ Immune System Disorders (RF 360) *Describe the disorder in box below.*
	☐ Prematurity (RF 142)	☐ Severe Food Allergies (RF 353) *Describe the allergy in box below.*	☐ Other Indicate another specific life threatening disorder/disease/medical condition that could adversely affect the participant's nutrition status in box below.
	☐ Failure to Thrive (RF 134)	☐ Gastrointestinal Disorders (RF 342) *Describe the disorder in box below.*	

Describe the disorder/allergy/medical condition checked above.

B. SPECIAL FORMULA

FORMULA REQUESTED:
(Refer to list on back of form)

REQUIRED CALORIE/FLUID OUNCE CONCENTRATION	DAILY AMOUNT REQUESTED	REQUESTED APPROVAL LENGTH:	
☐ Mix according to label instructions	_____ Max Allowed	☐ 1 Month	☐ 4 Months
☐ 22 cal/fl oz ☐ 24 cal/fl oz ☐ Other :_____	_____ ounces/day	☐ 2 Months	☐ 5 Months
	_____ cans/day	☐ 3 Months	☐ 6 Months (Max)

C. WIC SUPPLEMENTAL FOOD

Full provision of age/categorical appropriate WIC food will be provided unless otherwise indicated below:

☐ No WIC foods; provide formula only.
☐ Issue a modified food package **OMITTING** the WIC food checked below:

WIC Food for Infants (6-11 months)
☐ Infant Cereal
☐ Infant Fruits & Vegetables

WIC Food For Children (1-4 y/o) and Women
☐ Cow's Milk ☐ Soymilk ☐ Peanut Butter ☐ Legumes ☐ Breakfast Cereals
☐ Whole Grains ☐ Juice ☐ Fruits & Vegetables ☐ Eggs ☐ Cheese

[WHOLE MILK] WIC provides only **whole milk** for children (1 y/o) and **milk (skim thru 2%)** for children (≥ 2 y/o) and women. Whole milk can be issued to children (≥ 2 y/o) & women receiving special formula with qualifying condition(s), if prescribed.

- Does this participant need whole milk? ☐ Yes ☐ No
- If yes, describe medical condition(s): ______________________________

[SOYMILK] Issuing soymilk to children requires medical documentation. Personal preference is NOT allowed.

- Does this child need soymilk? ☐ Yes ☐ No
- If yes, select medical condition(s): ☐ Milk Allergy (RF353) ☐ Lactose Intolerance (RF355) ☐ Vegan Diet (RF425 children) (RF427 women)

[CHEESE] Issuing more than one pound of cheese as a milk substitute to children and women requires medical documentation.

- Does this participant need more than one pound of cheese? ☐ Yes ☐ No
- If yes, does this participant have lactose intolerance (RF 355)? ☐ Yes ☐ No

D. SPECIAL INSTRUCTIONS FOR FORMULA AND/OR SUPPLEMENTAL FOOD

E. HEALTH CARE PROVIDER INFORMATION (COMPLETED BY PRESCRIPTIVE AUTHORITY LICENSED BY THE STATE)

NAME (PRINT):	PHONE:	DATE (MMDDYY):
SIGNATURE: (Signature stamps NOT allowed)	☐ MD ☐ DO ☐ PA ☐ NP ☐ CNS ☐ CNM	

F. WIC USE ONLY (Must complete section in its entirety)

☐ APPROVED	WIC 27 Valid: Start Date (MMDDYY) ___________ End Date (MMDDYY) ______	STATE WIC ID:
☐ DISAPPROVED	If disapproved, did you contact HCP? ☐ Yes ☐ No	
SIGNATURE: ☐ RD ☐ NUTRITIONIST ☐ CPA	DATE (MMDDYY):	
AGENCY NAME:	AGENCY NUMBER:	

I. WIC APPROVED FORMULAS AND MEDICAL FOOD LISTING

A. Contract Infant Formulas (Rebate)

Enfamil Premium Infant
Enfamil Gentlease
Enfamil ProSobee

1. Contract infant formulas will be given unless a health care provider diagnoses a medical condition that warrants a specialty formula.
2. A medical documentation form (WIC 27) must be completed for prescribing infant formula for children (12-59 months) with qualifying medical condition(s). (Max. Approval Length: 6 months)
3. The WIC 27 form must be completed when dilution of formula is different from the instructions on the product label.
4. For more information about WIC approved formulas and/or medical foods not listed on this form, please contact the WIC State office at 1-800-392-8209.

B. Special Formulas - Infants

Enfamil A.R*
Elecare For Infant DHA/ARA
EnfaCare
Enfamil Human Milk Fortifier
Enfaport LIPIL
NeoCate Infant Formula DHA/ARA
Nutramigen (Conc. R-T-U)
Nutramigen AA/PurAmino
Nutramigen W/ Enflora LGG (Powder)
Pregestimil
RCF (Ross Carbohydrate Free – Metabolic)
Similac Expert Care Alimentum
Similac Expert Care NeoSure
Similac PM 60/40

* Enfamil A.R. is a contract formula; however, it requires a completed WIC 27 form.

Formulas in Nursettes (2 fl oz container)

Enfamil LIPIL w/ Iron Non-premature (24 cal)
Enfamil Premature Iron Fortified (24 cal)
Pregestimil (24 cal)
Similac Special Care W/ Iron (24 cal)
Similac Special Care W/ Iron (30 cal)

C. Special Formulas – Children

Boost Kid Essentials
Boost Kid Essentials 1.5 Cal
Boost Kid Essentials W/ Fiber 1.5 Cal
Bright Beginnings Soy Pediatric Drink
Compleat Pediatric
Compleat Pediatric Reduced Calorie
Enfagrow Gentlease - Toddler
Enfagrow Premium - Toddler
Enfagrow Soy - Toddler
E028 Splash
Elecare Jr.
Isosource 1.5 W/ Fiber
Glucerna Shake
Ketocal 3:1
Ketocal 4:1
Monogen
NeoCate Jr. W/ Prebiotics
NeoCate Jr.
Nutren Jr.
Nutren Jr. W/ Fiber
Pediasure
Pediasure W/ Fiber
Pediasure 1.5
Pediasure 1.5 W/ Fiber
Pediasure Enteral Formula 1.0 Cal
Pediasure Enteral Formula 1.0 Cal W/ Fiber
PediaSure Peptide 1.0 Cal
PediaSure Peptide 1.5 Cal
Pepdite Jr.
Resource Breeze
Renastart
Peptamen Jr.
Peptamen Jr. 1.5
Peptamen Jr. W/ Fiber
Peptamen Jr. W/ Prebio
Portagen
Suplena
Super Soluble Duocal
Vivonex T.E.N.

D. Special Formulas - Women

Boost
Ensure
Isosource 1.5 W/ Fiber
Glucerna Shake
Peptamen
Peptamen W/ Prebio
Peptamen 1.5
Portagen
Resource Breeze
Suplena
Tolerex
Vivonex T.E.N.

II. Maximum Monthly Allowances (Reconstituted Amount/Month)

Feeding Options	Type of Formula	0-1 month	1-3 months	4-5 months	6-11 months
Non-Breastfeeding Infant	Reconstituted Liquid Concentrate	806 fl oz	806 fl oz	884 fl oz	624 fl oz
	Ready-To-Use/Feed	832 fl oz	832 fl oz	896 fl oz	640 fl oz
	Reconstituted Powder	870 fl oz	870 fl oz	960 fl oz	696 fl oz
Partially Breastfeeding	Contact the local WIC provider for the maximum monthly allowance if the infant is partially breastfed.				

Category	Powder (Reconstituted Yield)	Liquid Concentrate (Reconstituted Yield)	Ready-To Use/Feed
Children with Qualifying Condition(s)	910 fl oz / month	910 fl oz / month	910 fl oz / month
Women with Qualifying Condition(s)	910 fl oz / month	910 fl oz / month	910 fl oz / month

III. Milk, Soymilk, Lactose Free Milk, Cheese and Medical Documentation (WIC 27)

Food Items	Children 1 y/o	Children 2 – 4 y/o	• Pregnant Women • Non Breastfeeding Women	• Fully breastfeeding women • Partially breastfeeding women with multiple infants • Pregnant women carrying multiples • Pregnant women who are still breastfeeding.
Whole milk	**	*	*	*
Soymilk	*	*	**	**
> 1 lb. of cheese as a milk substitute	*	*	*	*

* Requires medical documentation (WIC 27) ** Allowed without medical documentation