gobreastmilk.org
24-Hour Breastfeeding Hotline
1-800-833-4642

WIC ARIZONA

Effective January 29, 2019

Formula and Food Request

Please Complete All Sections

1. Patient's Name: _____ **2. Patient's Date of Birth:** _____

3. Type of Formula Requested

Formula Name	Powder	Concentrate	RTF
Similac Advance	☐	☐	☐
Similac Soy Isomil	☐	☐	☐
Similac Sensitive	☐	NA	☐
Similac for Spit-up	☐	NA	NA
Similac Total Comfort	☐	NA	NA
Alimentum*	☐	NA	☐
Nutramigen*	☐	☐	☐
Gerber Extensive HA*	☐	NA	NA
Similac Neosure*	☐	NA	☐
Enfamil Enfacare*	☐	NA	☐
Pediasure* (must meet WIC criteria for issuance)	NA	NA	☐
Other: _____	☐	☐	☐

*WIC Special Formula: When requesting this formula, complete this form, but also request formula from AHCCCS if patient qualifies (see AHCCCS Policy 430, AHCCCS Policy 430 Attachment B)

4. Diagnosis (select one or more diagnoses)

Gastroesophageal Reflux Disease	☐
Severe Food Allergy	☐
Intestinal Malabsorption	☐
Failure to Thrive	☐
Low Birth Weight	☐
Prematurity	☐
Developmental Disorder	☐
Metabolic Disorder	☐
Immune System Disorder	☐
Inappropriate Growth Patterns‡	☐
Formula Intolerance‡	☐

Other Diagnosis:

‡May only be selected for Similac Sensitive, Spit-up, or Total Comfort

5. Amount of Formula Requested Per Day

☐ WIC Maximum OR Prepared Fluid Ounces per day: _____

6. Length of Time for Food and/or Formula Request

☐ Until first birthday OR Number of Months: _____

7. WIC Foods

Depending on age and category, WIC foods may include whole grains (bread, rice, pasta, tortillas), breakfast cereal, fruits, vegetables, beans, canned fish, peanut butter, milk, cheese, yogurt, eggs, juice, and infant fruits, vegetables, and meats.

The WIC Registered Dietitian/Nutritionist will determine which foods to provide unless indicated below

☐ Check this box to **NOT GIVE ANY** WIC Foods to this patient starting at age 6 months and beyond **or**

List specific WIC Foods to **NOT GIVE** to this patient starting at age 6 months

8. Healthcare Provider's Information

Healthcare Provider's Title (circle one) M.D., D.O., P.A., N.P., N.M.D., C.N.M., H.M.D.

Provider's Name: _____ Provider's Phone Number: _____

Provider's Signature: _____ Today's Date: _____