Pennsylvania WIC Program
Formula Authorization Form

Effective Date: November 15, 2024

Client's First & Last Name: _____ **Birth Date:** _____

Parent/Caregiver's First & Last Name: _____

1. **Formula requested:** _____

WIC is authorized to provide a different brand's comparable formula, if needed. ☐ *Yes* ☐ *No*

Ready-to-Feed Required (must be justified by medical condition below): ☐ Yes ☐ No

Via tube feeding? ☐ Yes ☐ No

Special instructions for preparation and use (if necessary):

2. **Amount requested:** _____ oz/day (if formula) _____ Tbsp/day (if modular formula)

☐ *WIC maximum monthly allowance per CFR 246.10(e)(9) - (for infant formulas only)*

3. **Length of use:** ☐ 1 month ☐ 3 months ☐ 6 months ☐ through this date_____ (max 6 months)

Monthly renewal required for pre-discharge premature formulas.WIC encourages re-challenge with primary infant formula after solids have been introduced, generally at 6 months of age, with provider approval.

4. **Qualifying Medical Condition(s):** _____ ICD-10 Code: _____

(Justifies the authorization of above formula).

5. **Please check all applicable WIC food restrictions:** ☐ No WIC Food Restrictions

Infants (6-11 months): ☐ infant cereal ☐ infant meat ☐ infant fruits and vegetables

Children & Women:

☐ cow's milk	☐ canned fish	☐ breakfast cereal
☐ cheese	☐ eggs	☐ whole grains
☐ yogurt	☐ beans (canned or dried)	☐ fruits & vegetables
☐ tofu	☐ peanut butter	☐ 100% fruit juice
☐ soy beverage		

Length of restriction: □ 1 month □ 3 months □ 6 months □ other: _____

Reasons/Instructions/Comments: _____

_____

6. **Dairy Authorization for Women and Children Only:**

☐ **Please provide the WIC standard milk and yogurt types which are:**
- whole fat milk and yogurt for children 12-23 months.
- 1% or skim milk and low-fat/non-fat yogurt for children 2-5 years and women.

☐ **Please provide an alternate milk and yogurt type as selected below:**
- children 12-23 months: ☐ *2% milk* ☐ *1% or skim milk* ☐ *soy beverage* ☐ *low-fat/non-fat yogurt*

- children 2-5 years and women: ☐ *whole milk** ☐ *2% milk* ☐ *soy beverage* ☐ *whole fat yogurt*

*Whole milk may be provided for women and children age 2 and over, *only* if a special formula is prescribed.

Signature: _____ **Date:** _____
Physician, Certified Registered Nurse Practitioner, Certified Nurse Midwife, Physician Assistant

Printed Name: _____

Medical Office/ Clinic: _____ **Telephone:** _____

Address: _____ **Fax:** _____

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