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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