



Healthcare Provider:		Return form to:	
Address:			
Phone:	Fax:		
Provider DEA:			
Patient's Name:		Date of Birth: / /	
MaineCare ID#:		Parent/Guardian:	
Pharmacy Name:		Pharmacy Address:	
Pharmacy Fax:		Pharmacy NABP/NPI #:	
<p>Please specify the underlying qualifying medical diagnosis(es): Please note that non-specific conditions such as rash, intolerance, underweight, fussiness, colic, spitting up, vomiting, gas, or constipation, or requests strictly for management of body weight will <u>not</u> be considered indications for a medical formula.</p>			
<p> <input type="checkbox"/> Prematurity (<37 weeks gestation) <input type="checkbox"/> Developmental Delay </p> <p> <input type="checkbox"/> Food Allergies (specify): _____ </p> <p> <input type="checkbox"/> GI Disorder/Malabsorption Syndrome (specify): _____ </p> <p> <input type="checkbox"/> Failure to Thrive (specify underlying medical condition): _____ </p> <p> <input type="checkbox"/> Other (specify): _____ </p>			
<p>The Maine CDC WIC Nutrition Program issues only contract infant formula for partially breastfed or nonbreastfed infants who are using standard cow's milk or soy formulas. The current contract formulas include: Similac Advance (20 kcal/oz), Similac Isomil (20kcal/oz), Similac Sensitive (19kcal/oz), Similac Total Comfort (19 kcal/oz) and Similac for Spit-Up (19 kcal/oz).</p> <p>The 19kcal/oz formulas require WIC staff to obtain medical documentation prior to issuance.</p> <p>All prescriptions for medical formulas are subject to WIC approval and provision based on program policies. Please refer to the Maine CDC WIC Nutrition Program formulary for more information: http://www.maine.gov/dhhs/mecdc/health-equity/wic/health/index.shtml#F</p>			
<p>Formula Prescribed: _____ Prescribed ounces or cc/day _____</p> <p>Tube feeding <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Special instructions for preparation, dilution or tube feeding (if applicable):</p>			
<p>Duration of prescription: <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months</p>			
<p>Foods to be omitted in patient's diet:</p> <p><input type="checkbox"/> None <input type="checkbox"/> Omit: _____</p>			
<p><input type="checkbox"/> WIC Registered Dietitian may assess for and provide appropriate WIC foods (such as lactose free milk, provision of infant solids at 6 months of age and whole milk at 12 months) to my participant receiving a medical formula. If this checkbox is not selected, WIC must have written authorization from HCP to provide foods.</p>			
<p><input type="checkbox"/> Whole Milk for child ≥24 months or woman (must also be prescribed medical formula for qualifying medical condition)</p>			
HEALTH CARE PROVIDER SIGNATURE (MD, DO, PA, NP):		Date:	
<p>Printed Name (Health Care Provider):</p>			