

The City of El Paso Department of Public Health-WIC Program
Non-contract Formula Request Form

Name _____ Date of Birth _____
 Height/Length* _____ Weight* _____ Date Taken _____ Amount of formula needed per day _____
 (*Data must be current within 7 days for infants or 30 days for children)

List history of formulas previously tried and resulting symptoms: _____

Formula (Circle the formula and indicate the desired months of issuance.)	Length of Issuance Infant 1-12 months Child/adult 1-6 months	Diagnosis/condition (Reason for Issuance)
Contract Formulas: Similac Advance Early Shield Similac Sensitive Isomil Advance	_____ Months	<i>WIC will only issue a formula for the reasons indicated.</i> Iron-fortified milk based infant formula with prebiotics for routine feeding. Lactose-free, milk-based, Iron-fortified infant formula. Milk-free, lactose-free, sucrose-free, soy protein formula for routine feeding of infants intolerant to milk protein, lactose or sucrose.
Good Start Nourish Plus Good Start Gentle Plus Good Start Soy Plus Enfamil Gentlease LIPIL Enfamil LIPIL Enfamil Premium Enfamil ProSobee LIPIL	_____ Months (3 months maximum per request)	Allergy or intolerance to Similac Advance, Similac Advance Early Shield, Similac Sensitive, Isomil Advance. <i>WIC policy states that participants receiving these milk or soy formulas MUST be challenged with contract formula every TWO-THREE months. If you feel this is medically contraindicated, PLEASE INDICATE REASON:</i>
Similac Isomil DF	_____ Days	Diarrhea due to gastrointestinal virus/ infection or antibiotic use. May be issued up to 10 days.
Nutramigen LIPIL	_____ Months	Milk and/or soy allergy; GERD
Alimentum	_____ Months	Allergy or sensitivity to intact protein; GERD; malabsorption; malabsorption with corn allergy. <i>Note: Powder is not corn free. Powder will be issued unless corn allergy is indicated.</i>
Pregestimil LIPIL	_____ Months	Malabsorption; malabsorption with allergy or sensitivity to milk, soy, and/or intact protein
Similac Special Care 24 Enfamil LIPIL Premature 24 Good Start Premature 24	1 month only / request 1 month only / request	Prematurity. Cannot issue if CURRENT weight is over 8 lbs. Prematurity. Cannot issue if CURRENT weight is over 5 ½ lbs.
Similac NeoSure EnfaCare LIPIL	(See Diagnosis) _____ Months	May be issued using the following guidelines: Birth wt. 4lbs - 5lbs 8oz, can issue up to 6 months of age Birth wt. 3lbs 5oz – 4lbs, can issue up to 9 months of age Birth wt. <3lbs 5oz, can issue up to 12 months of age
Similac PM 60/40	_____ Months	Renal, cardiac or other condition that requires lowered minerals
Portagen Monogen	_____ Months	Liver disease; pancreatic insufficiency; chylothorax
Similac Sensitive RS Enfamil AR LIPIL	_____ Months	Gastroesophageal reflux disease (GERD); not to be issued for uncomplicated GER (benign spitting up).
Similac Human Milk Fortifier Enfamil Human Milk Fortifier	_____ Months	SHMF may be issued until the infant weighs 5 ½ lbs. EHMf may be issued until the infant is consuming 25 packets a day.
Elemental infant formula Neocate Elecare DHA/ARA	_____ Months	Allergy to intact protein and casein hydrolysates; Malabsorption; Note: Alimentum, Nutramigen LIPIL, or Pregestimil LIPIL needs to have been tried prior to issuing unless medically contraindicated.
Toddler Soy Formulas Similac Go and Grow Soy Next Step ProSobee LIPIL Good Start Soy Plus 2	_____ Months	Milk allergy in a child older than 1 year of age

Toddler Milk-Based Products. Similac Go & Grow Milk Next Step LIPIL Good Start Gentle Plus 2	_____ Months	Over age 1 with medical need for 20 cal/oz product. Possible reasons include: prematurity with need for catch up growth, developmental delay, oral-motor feeding problems
Pediatric Tubefeeding formulas Pediasure Enteral Pediasure Enteral with Fiber Compleat Pediatric	_____ Months	Tubefeedings; oral motor feeding disorders; medical condition that increases calorie needs.
Pediatric Oral Products Nutren Junior Pediasure Pediasure with Fiber Bright Beginnings Soy Pediatric Drink Boost Kid Essentials 1.5 Boost Kid Essentials 1.5 FBR	_____ Months _____ cans per day	Oral motor feeding disorders; FTT from underlying medical condition; medical condition that increases calorie requirements beyond what is expected for age. Diagnosis: _____
Elemental and Semi-Elemental Pediatric Products Peptamen Jr. Peptamen Jr. 1.5 Neocate Jr. Neocate One + Pepdite One + EO28 Splash	_____ Months	Malabsorptive conditions; short bowel syndrome; medical condition requiring an elemental diet (please Specify): Diagnosis: _____
Pregnant, Breastfeeding or Postpartum Women Boost with Fiber Boost Ensure with Fiber Ensure Nutren with Fiber Nutren	_____ Months	Tubefeeding; oral motor feeding disorder; Medical condition that increases calorie requirements (please specify): Diagnosis: _____
Modular Products Duocal Polycose Ross Carbohydrate Free MCT Oil Microlipids	_____ Months	Please specify the medical need for the product:
Metabolic formulas Specify: _____	_____ Months	Metabolic disorders
Formula not listed above. Specify: _____	_____ Months	Diagnosis or reason for request for formula

Name (Printed) _____
Signature/Title _____ Date _____ Phone # _____

MD, DO, PA, NP

Please complete and fax right away to (915) _____ to _____

If you have any questions, contact _____ phone (915) _____

<http://www.elpasotexas.gov/forms.asp>