New Jersey Department of Health
WIC Services

MEDICAL DOCUMENTATION FOR WIC FORMULA AND APPROVED WIC FOODS FOR INFANTS, CHILDREN AND WOMEN

WIC Clinic	Phone	Fax

Please complete entire form. Fax the completed form to the WIC clinic or have your patient return the document to the WIC Clinic. Thank you!

PLEASE NOTE: It is the responsibility of the health care provider to provide close medical oversight and instructions to participants issued exempt infant formula, WIC-eligible medical foods and/or supplemental foods that require medical documentation. This responsibility cannot be assumed by personnel at the WIC State or local agency.
Re-authorization is required every three months.

- **No authorization is necessary for: Enfamil Infant, Enfamil Gentlease and Enfamil Prosobee**

Patient Name (First and Last)	Current Height/Length:
Date of Birth	Current Weight:
Parent/Caregiver Name (First and Last)	Date

1. Formula Requested: _____

   Amount Requested: ☐ Maximum Allowable OR ☐ _____ ounces/day (if formula)

   Physical Form: ☐ Powder ☐ Concentrate

   Intended Length of Use: ☐ 1 Month ☐ 2 Months ☐ 3 Months

2. Qualifying Condition(s) *(Justifies the medical need.)* ***(Complete and submit Page 2 with this form.)***

3. Can patient receive supplemental (or other WIC) foods in addition to formula or medical food? ☐ Yes ☐ No
   *(If Yes, please check the foods below that your patient **CAN/IS** eating.)*

   Infants (6-11 months only):

   ☐ Infant Cereal ☐ Infant Vegetable or Fruit

   Children and Women:

   ☐ Juice ☐ Breakfast Cereal ☐ Whole Wheat Bread or Other Whole Grains ☐ Eggs
   ☐ Vegetables and Fruits ☐ Milk or Milk Substitutes ☐ Legumes ☐ Canned Fish* ☐ Peanut Butter

   Reasons/Instructions/Comments: _____

   _____

   **Fully breastfeeding women, women partially breastfeeding multiple infants from the same pregnancy, women pregnant with multiple infants, and pregnant women who are mostly breastfeeding an infant are the only WIC participant categories eligible to receive these foods.*

Health Care Provider Name *(Print)*	☐ MD ☐ DO ☐ APN ☐ PA-C
Medical Office/Clinic	Telephone Number
Medical Office/Clinic Address	Fax Number
Health Care Provider Signature	Date

WIC OFFICE USE ONLY:			
Reviewed by CPA Name:	☐ Approved # of months: _____ ☐ Disapproved	Date:	If required: MS and/or RD CPA Name:

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QUALIFYING CONDITIONS

(Please check appropriate Qualifying Conditions.)

Participant Category	Non-Qualifying Conditions	Qualifying Conditions
Infants (up to 12 months)	• Non-specific formula or food intolerance • Only condition is a diagnosed formula intolerance or food allergy to lactose, sucrose, milk protein or soy protein that does not require an exempt infant formula	☐ Severe food allergies ☐ Milk and soy allergies ☐ Metabolic disorders ☐ Gastrointestinal disorder ☐ Mal-absorption disorders ☐ Premature birth ☐ Failure to thrive/severely underweight ☐ Low birth weight ☐ NG/Tube Fed ☐ Oral/motor feeding problems ☐ Immune system disorders ☐ Life threatening disorders
Children (up to five years of age)	• Solely for the purpose of enhancing nutrient intake or managing body weight without an underlying condition • Lactose intolerance • Participant preference	☐ Severe food allergies ☐ Milk and soy allergies ☐ Metabolic disorders ☐ Gastrointestinal disorder ☐ Mal-absorption disorders ☐ Premature birth ☐ Failure to thrive/severely underweight ☐ Low birth weight ☐ NG/Tube Fed ☐ Oral/motor feeding problems ☐ Immune system disorders ☐ Life threatening disorders
Women	• Solely for the purpose of enhancing nutrient intake or managing body weight without an underlying condition • Lactose intolerance • Participant preference	☐ Severe food allergies ☐ Milk and soy allergies ☐ Metabolic disorders ☐ Gastrointestinal disorder ☐ Mal-absorption disorders ☐ NG/Tube Fed ☐ Oral/motor feeding problems ☐ Immune system disorders ☐ Life threatening disorders