



Pennsylvania WIC Program Formula Authorization Form

Effective Date: May 5, 2025

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, Licensed Dietitian Nutritionist

Printed Name: _____

Medical Office/ Clinic: _____ Telephone: _____

Address: _____ Fax: _____