

Prescribing Guidance for Specialist Infant Formula Feeds in the management of mild to moderate Non-IgE Cows' Milk Allergy (CMA) and Lactose Intolerance

Version 2.0

Change History

Version Number	Change Details	Date
V1.0	➤ Guidance Document published	February 2022
V2.0	<ul style="list-style-type: none"> ➤ Inclusion of Dept. of Health Policy on De-Prescribing of Cows' Milk Allergy Formula for Children over 12 months ➤ Addition of link to UNICEF breastfeeding tool to aid feeding assessment ➤ Resources to support continued breastfeeding in initial management stages. ➤ Links to iMAP Home Challenge to confirm initial diagnosis. ➤ Table of Hypoallergenic Formulae and product selection information. ➤ Reminder of Deprescribing beyond 12 months Letter to service ➤ Amended quantities of formula to prescribe. ➤ Soy formula is no longer available in the UK. 	October 2025

The purpose of this guidance is to outline recommendations for the prescribing of infant formula for the management of mild to moderate non-IgE mediated cows' milk allergy (CMA) and lactose intolerance. This guidance replaces the previous SPPG infant feeding guidance (2022) and has been updated to include the [Dept. of Health Policy on De-Prescribing of Cows' Milk Allergy Formula for Children over 12 months](#). This prescribing guidance is intended for healthcare professionals including doctors, pharmacists, dietitians, health visitors and family nurses. For suspected IgE mediated CMA refer to a specialist allergy paediatrician.

1. Background and Context

In 23/24 over £5 million was spent on CMA milks in NI. NI spends considerably more per infant on prescribing specialised milks for CMA when compared to the rest of the UK (£111 per infant in NI compared to £57/£76 per infant in England/Wales).

Cows' milk allergy is shown to affect between 1.8% and 7.5% of infants in the first year of life. This may be an overestimate as Venter and colleagues confirmed cow's milk allergy, using the double-blind placebo-controlled food challenge for diagnosis, in only 1.0% of their population compared with a double prevalence of 2.3% using an open food challenge. Clinicians should therefore anticipate that between 2-3% of children having cows' milk allergy. Only among breastfed infants is the prevalence lower (0.5 %).

¹

Symptoms of CMA can be non-specific and can be confused with normal newborn behaviours, therefore it is important to carry out a full assessment prior to recommending a hypoallergenic formula or maternal milk-free diet.

This guidance covers all infants i.e. those who are breastfed, formula fed or combination fed.

Breastfeeding is the best form of nutrition for infants and this should be promoted, actively supported, and protected wherever possible.

2. Initial assessment of infants

A full face to face assessment is required to observe the infant's behaviours, both before, during and after feeding. A Health Visitor or Public Health Nurse may be best placed to carry out this assessment. Infants with a family history of atopic eczema,

¹ <https://www.allergyuk.org/about-allergy/statistics-and-figures/>

allergic rhinitis, asthma or family history of food allergies have a higher likelihood of developing CMA.

Persistent signs and symptoms that involve different/ multiple organ systems e.g. skin, GI, respiratory, and do not respond to typical therapeutic interventions, may indicate potential CMA.

[iMAP presentation algorithm](#) is a useful tool to help determine if the presenting symptoms are indicative of a likely CMA, and to help stratify the severity of the potential diagnosis e.g. mild/moderate/severe and IgE/non-IgE mediated. Please note, suggestion that soy formula may be used in children over 6 months not sensitised on IgE testing is no longer applicable as there are no longer any soy-based infant formulae commercially produced.

[UNICEF breastfeeding tool](#) should be used to assess infants who are breastfed.

Assessment should also consider the following points:

- Normal baby behaviour around crying, unsettledness etc and managing parental expectations in the newborn stage.
- Preparation of formula – [PHA guide to Bottlefeeding](#).
- Consider advising symptom diary keeping. If an infant has problems with feeding, bowels, vomiting, sleep or settling, a feeding or symptom diary can be very helpful in clarifying symptoms and finding the cause.
- Parents and carers should be encouraged to photograph skin reactions to help healthcare professionals with history taking, however these should not be shared with healthcare professionals for diagnostic purposes. A full face to face assessment is required prior to trial of dairy free diet.

3. When CMA is suspected

If the baby is breastfed, return to exclusive breastfeeding should be supported, where possible, in the initial management of suspected CMA. The level of cows' milk protein in breast milk is 100,000 times lower than that in cows' milk-based formula². A trial elimination of cows' milk from maternal (& babies' diet in infants who have begun solids) should be recommended for 2-4 weeks to see if symptoms resolve. Breastfeeding mothers need at least 1250mg³ of calcium each day, as well as 10mcg/400iu of Vitamin D. The [BDA Calcium Factsheet](#) contains information on good sources of calcium.

² <https://www.breastfeedingnetwork.org.uk/factsheet/cows-milk-protein-allergy-cmpa-and-breastfeeding/#:~:text=The%20level%20of%20cow%27s%20milk,forms%20of%20CMPA%20very%20rare.>

³ <https://www.bda.uk.com/resource/calcium.html>

Mothers should be advised that if they cannot meet their calcium requirements through diet alone they can purchase supplements from a wide variety of pharmacies, supermarkets or health food shops.

If return to exclusive breastfeeding is not an option (either due to parental choice or exclusively formula fed infant) then a trial of a hypoallergenic formula should be offered. Hypoallergenic formula should be trialled for 2-4 weeks to see if symptoms resolve.

- Management of mild-moderate non-IgE cows' milk allergy (CMA)

Refer to the [iMAP treatment algorithm](#)

4. Specialised Hypoallergenic Formulae available in the UK

Product choice	Category	Name of Infant Formula
First line choice – any eHF	Extensively hydrolysed peptide-based infant milks suitable from birth (eHF)	Aptamil Pepti 1® Aptamil Pepti Syneo® Mead Johnson Nutramigen 1 with LGG® Similac Arize® SMA Althéra®
First line choice if choosing to move to a follow-on	Extensively hydrolysed peptide-based milks suitable from 6 months (eHF)	Aptamil Pepti 2® Mead Johnson Nutramigen 2 with LGG®
Second line choice	Amino acid-based infant milks for non-metabolic disorders, suitable from birth (AAF)	Mead Johnson Nutramigen Puramino® Nutricia Neocate LCP® Nutricia Neocate Syneo® SMA Alfamino®
Specialist initiation only	Extensively hydrolysed peptide-based infant milks with medium chain triglycerides as the main fat source, suitable from birth N.B these formulae are for infants with impaired GI function OR malabsorption only	Aptamil Pepti-junior® Nutricia Infatrini Peptisorb®

Prescriptions for such products should be endorsed 'ACBS'.

(i) **1st Line: Prescribing eHF for infants**

- For formula fed infants the first step is to undertake an elimination trial with eHF, **including** where symptoms suggest severe allergy or suspected IgE allergy. If the infant is breastfed do not prescribe formula - the mother should remove all cows' milk containing foods from her own diet for the duration of 2-4 week elimination trial.
- A maximum of 6-8 tins of eHF should be prescribed to allow the elimination trial to take place.
- If an improvement in patient symptoms is seen after this trial **no further prescriptions** for eHF should be issued and a home challenge with cows' milk containing formula should take place. In the case of breastfed (or combination fed) infants, the mother should revert to normal diet containing cows' milk foods over the course of one week. This reintroduction should take place approximately 2-4 weeks after commencing trial of eHF or maternal exclusion of cows' milk containing foods.
- **Details of this home challenge should be highlighted to parents at the outset of treatment.** [**IMAP Home Reintroduction to Confirm or Exclude diagnosis**](#) provides the practical details for the family of how to carry out the reintroduction at home.
- If, after the home challenge, symptoms do not return, then CMA is not suspected and no further formula should be prescribed.
- If, after the home challenge, symptoms return, then in the case of formula fed infants further eHF can be prescribed and if symptoms again improve then CMA is confirmed. Only then should long-term prescribing with regular review proceed.
- Following a diagnosis of CMA, refer to specialist dietitian or paediatric consultant following local processes and access criteria. The dietitian or specialist should draw up a care plan for weaning and discontinuation.
- If after the initial 2-4 week elimination trial using eHF, no clear improvement in symptoms is seen but CMA is still suspected prescribers should consider a trial of an amino acid-based formula (AAF) as detailed below; and refer patient to paediatrics or secondary care allergy clinic.

(ii) 2nd line: Prescribing AAF for infants

Data suggests that 90% of children with true CMA should be effectively managed on an eHF formula.

Therefore, AAF should **only** be initiated following an initial trial of eHF for at least 2-4 weeks.

Children with faltering growth due to enterocolitis or proctitis, severe atopic dermatitis and symptoms during exclusive breastfeeding are more likely to require AAF.

Trial of step-down to an eHF after 6 months of using an AAF, unless advised otherwise by paediatric consultant or dietitian (however, prescribing may revert back to AAF if eHF not tolerated).

(iii) Ongoing prescribing and review of patients in line with Dept. of Health Policy

After confirmation of CMA, a cows' milk free diet should be followed until 9-12 months of age OR for approx. 6 months. A planned reintroduction of cows' milk is then needed to determine if tolerance has been achieved. A multidisciplinary approach is recommended to ensure appropriate follow-up of patients. Further information on planned reintroduction can be found in the GPFIN treatment guidance [iMAP Milk Ladder](#)

[Department of Health policy](#) states that from 1st September 2024 practices should no longer prescribe specialised formula for cows' milk allergy (CMA) for children over 12 months of age.

There are some **exceptions** where it will be appropriate to continue prescribing these specialised formulas to children who are older than 12 months of age. These children will already be under review on an ongoing basis by Trust Dietetic Services, who will advise regarding specific care plans and includes those with:

- Multiple food allergies
- Elemental diet requirement
- Gastro-intestinal disorders
- Short bowel syndrome
- Confirmed CMA who also have faltering growth/poor dietary intake

Children age over 12 months where de-prescribing of specialised formula is appropriate but are still exhibiting symptoms of CMA can safely transition to a shop bought plant-based milk substitute fortified with calcium, vitamin D and iodine. Rice milks are not suitable for children under 5 years of age due to trace levels of arsenic.

Resources for parents to assist with de-prescribing can be found in the letter regarding the introduction of the policy [CMA-deprescribing-letter-to-service-190824.pdf](#)

5. Breastfed infants

Incidence of CMA is much less prevalent in infants who are breastfed. Continued breastfeeding should be encouraged and supported where possible when breastfed babies present with possible CMA as this is usually the best management for CMA.

Refer mother and baby to the Paediatric Dietetic Service who will advise the mother to follow a cows' milk free diet for 4 weeks; they will be seen as urgent referrals. Breastfeeding mothers need at least 1250mg of calcium each day, as well as 10mcg/400iu of Vitamin D. The [BDA Calcium Factsheet](#) contains information on good sources of calcium. Mothers should be advised that if they cannot meet their calcium requirements through diet alone they can purchase supplements from a wide variety of pharmacies, supermarkets or health food shops Specialist hypoallergenic formula should only be considered when there is defined a clinical need after thorough assessment.

6. Quantities to Prescribe (Powdered formula)

Following diagnosis, on initiation of any new formula, it is advisable to **prescribe 1-2 tins maximum initially** to assess tolerance and palatability. After tolerance has been confirmed the number of tins prescribed for 28 days should be based on age.

Prescribers should include a date for review in prescription directions for when children are approaching 12 months as per the Deprescribing CMA formula beyond 12 months Policy.

Age of child	Number of tins for 28 days*
Under 6 months	4 -12 x 400g tins or 2-6 x 800g tins
6-9 months	8 x 400g tins or 4 x 800g tins
9-12 months	6 x 400g tins or 3 x 800g tins
Over 12 months – listed exceptions only	If infant formula is still required, quantity should be as per recommendation from paediatric dietetic team.

*Quantities are an average estimate, some children may require larger quantities e.g. those with faltering growth, and some children may require smaller quantities e.g. mixed fed children. This table provides guidance only.

7. Lactose intolerance

Primary lactose intolerance is rare. Lactose-free infant milks can be bought at a similar cost to standard infant formula and should not be prescribed. Lactose-free infant formula should not be used beyond 18-24 months and children can be weaned onto equivalent lactose-free milks purchased at supermarkets from 12 months old. Ensure good calcium intake if cows' milk and milk products are excluded – the BDA calcium factsheet is a useful resource for ensure adequate dietary calcium intake is met <https://www.bda.uk.com/resource/calcium.html>

8. Soy-based formula

Soy-based formula is no longer available in the UK.

Summary of actions for those recommending or prescribing formula:

- Follow the steps above in the management of suspected CMA. Discuss the importance of home challenge with cows' milk protein to confirm diagnosis at initiation of trial of treatment as well as advising that prescribing will stop at 12 months.
- Discourage parents from frequently changing milks.
- During review of older babies, establish if the child can tolerate cheese, yogurt or other dairy products.
- Review infants 12 months and over who are prescribed formula with a view to de-prescribing in line with DoH Policy.
- Healthcare Professionals should refer to COMPASS for analysis of CMA prescribing patterns in their practice/area.
- Add review dates to prescription directions.
- Do not initiate formula in children over one year.
- Direct parents and carers to [Patient Zone](#) for further information and resources.

This guidance should be used in conjunction with: -

1. [The Milk Allergy in Primary Care \(MAP\) Guideline 2019 | The GP Infant Feeding Network \(UK\) \(gpifn.org.uk\)](#)
2. British Dietetic Association Information on specialist milks for CMA [Milk allergy: Food Fact Sheet](#)
3. [NICE Clinical Guideline 116, Food allergy in under 19s: Assessment and Diagnosis.](#)
4. [Cow's milk allergy in children | Health topics A to Z | CKS | NICE](#)
5. [NICE pathway Postnatal care: Planning and supporting babies' feeding.](#)
6. [https://infantmilkinfo.org/wp-content/uploads/2024/06/Specialised Milk Allergies June24 Final.pdf](https://infantmilkinfo.org/wp-content/uploads/2024/06/Specialised_Milk_Allergies_June24_Final.pdf)

Prepared by SPPG Pharmacy & Medicines Management Team with input from Trust Paediatric Dietitians/Public Health Nursing. Version 2.0 September 2025 Review Date September 2028.