South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.dhhs.state.sc.us

April 15, 2005

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MEDICAID BULLETIN

TO: **Providers Indicated**

SUBJECTS:
- **I. Submission of Correct Days' Supply on Pharmacy Claims**
- **II. Billing Metric Decimal Quantities for Dispensed Pharmaceuticals**
- **III. "Brand Medically Necessary" Prescriptions Billed to Medicaid**
- **IV. South Carolina Medicaid Preferred Drug List – Additional Therapeutic Classes**

I. Submission of Correct Days' Supply on Pharmacy Claims

The South Carolina Department of Health and Human Services (DHHS) reimburses pharmacy providers for a maximum one-month supply of medication per prescription or refill. DHHS defines a one-month supply as a maximum 34 days' supply per prescription for non-controlled substances. When submitting pharmacy claims, it is important to record ***accurately*** the actual days' supply of medication dispensed (e.g., a 28-tablet package of oral contraceptives should be billed as a 28 days' supply, not a 30 days' supply).

DHHS has noted that pharmacy claims for many products, especially non-tablet or non-capsule product formulations (e.g., ophthalmic solutions, dermatologicals, insulin, etc.) are being submitted with an inaccurate days' supply. The Drug Utilization Review programs (both prospective and retrospective) rely entirely upon billing information from pharmacy providers to determine whether beneficiaries are over- or underutilizing medications. Additionally, submission of erroneous

prescription billing information leads to invalid reporting by DHHS and potentially, Medicaid overpayments. Pharmacy providers are urged to discontinue use of any "routine values" in the days' supply field that are being used to avoid rejection of prescription claims or to circumvent the "refill too soon" edit. ***Information submitted on pharmacy claims must be entirely accurate.*** The pharmacist-in-charge at each Medicaid-enrolled pharmacy is asked to oversee and ensure compliance with this billing requirement.

II. Billing Metric Decimal Quantities for Dispensed Pharmaceuticals

Pharmacy providers should note that DHHS ***requires*** use of the "metric decimal" quantity on pharmacy claims. A "rounded" number must NOT be submitted as the billed quantity when the dispensed amount is a fractional quantity. **If the dispensed quantity is a fractional amount, then the billed quantity must accurately reflect the specific metric decimal quantity that is dispensed.** To further clarify, the *billed quantity* of a product packaged in *fractional quantities only* should be a numerical factor of that product's metric decimal package size. Billing incorrect quantities negatively affects quarterly rebate invoice data and results in under- or overpayment to providers. Furthermore, mispaid claims due to inaccurate quantities are subject to audit and if appropriate, recoupment of Medicaid payments.

III. "Brand Medically Necessary" Prescriptions Billed to Medicaid

The use of the "Brand Medically Necessary" claims filing designation (*i.e.*, DAW code of '6') is reserved only for those brand name products with upper limits of payment restrictions (*i.e.*, FUL or SCMAC) established for that date of service. (See this link, **http://southcarolina.fhsc.com/providers/rx/documents.asp,** to review the listing of drugs with an FUL or SCMAC. Click "MAC List" under the heading of "Listings." This listing is updated monthly.)

The pharmacist must only use the DAW of '6' designation to obtain higher Medicaid reimbursement when the prescriber certifies in his/her own handwriting that a specific brand is medically necessary for a particular patient. The handwritten phrase "brand necessary" or "brand medically necessary" must appear on the face of the prescription. A dual line prescription blank (*e.g.*, signing on the "Dispense As Written" line) does not satisfy the brand medically necessary requirement, nor does a blanket statement from the prescriber stating that the patient must have a brand name product satisfy this federal requirement. **The prescriber's (NOT his or her staff or agent's) handwritten notation on the prescription certifying "brand necessary" or "brand medically necessary" is the only permissible means for obtaining Medicaid reimbursement for the brand name product.**

To avoid recoupment of Medicaid monies, care should be taken ***prior*** to billing to ensure that appropriate claims filing procedures have been followed. Prior to billing, the prescriber must complete the South Carolina Medicaid MedWatch form and certify the prescription as "brand necessary" or "brand medically necessary." Providers should note that those brand name Narrow Therapeutic Index (NTI) drugs

that have an established FUL or SCMAC on the date of service do NOT require prior authorization via approval of the South Carolina Medicaid MedWatch form; however, *NTI drugs are subject to the previously described "brand necessary" or "brand medically necessary" certification requirements.* Prescriptions for NTI drugs which are not properly encrypted are subject to postpayment review and recoupment of Medicaid monies.

IV. South Carolina Medicaid Preferred Drug List – Additional Therapeutic Classes

During April 2005, implementation of South Carolina Medicaid's Preferred Drug List (PDL) will be completed with an additional group of therapeutic classes. Attached to this bulletin is a comprehensive listing of products within all therapeutic classes that comprise the South Carolina Medicaid PDL.

Prescribers are encouraged to write prescriptions for the "preferred" products rather than prescribing those drugs that require PA. However, if a prescriber is concerned that the patient's clinical status necessitates therapy with a PA-required drug, the prescriber is advised to initiate a PA request. A prospective PA request submitted by the prescriber (and approved by the First Health Clinical Call Center) will prevent rejection of prescription claims at the pharmacy due to the PA requirement.

All PA requests must be telephoned or submitted to the First Health Clinical Call Center by the prescriber or the prescriber's designated office personnel. The toll-free telephone number for the Clinical Call Center is 866-247-1181 and the fax number is 888-603-7696 (toll-free).

As with the previously implemented PDL therapeutic classes, pharmacists should note that for approximately four to six weeks during the initial implementation period, soft edits [i.e., electronic messages that are received via point of sale] will be transmitted when pharmacy claims are submitted for products that will require PA when that group of drugs is fully implemented. The soft edit serves as notification to the pharmacist that PA will be necessary in the future. The soft edit will not cause the claim to reject; however, pharmacists are asked to take this opportunity to inform both the prescriber and beneficiary of the eventual PA requirement. [PDL-related prior authorization requirements are applicable to all fee-for-service S.C. Medicaid beneficiaries, including those participating in the SILVERxCARD program.]

Effective with dates of service May 31, 2005, hard edits will be activated (i.e., pharmacy claims without PA approval will be denied) for "non-preferred" products within the therapeutic classes listed below.

PDL Therapeutic Classes With Hard Edits Beginning May 31, 2005	
1) Alzheimer's Agents: *Cholinesterase Inhibitors*	**4)** Topical Immunomodulators
2) Herpes Antivirals (Oral Agents)	**5)** Urinary Tract Antispasmodics
3) Onychomychosis Antifungals (Oral Agents)	

Listed in the following table (in the column labeled "April 2005") are the therapeutic classes that will be implemented with soft edits in April 2005. Previously implemented therapeutic classes (May 2004, August 2004, September 2004, December 2004, and February 2005) are also listed.

PDL Therapeutic Classes That Comprise The PDL *FIRST HEALTH CLINICAL CALL CENTER: 866-247-1181 (toll-free)*	
April 2005	*February 2005*
Alzheimer's Agents: *Cholinesterase inhibitors*	Anti-Cholinergics: COPD Therapy
	Anti-Emetics: 5-HT_3 Receptor Antagonists
Herpes Antivirals	Glaucoma Agents: ◆ Alpha-2 Adrenergic Agents ◆ Beta Blockers ◆ Carbonic Anhydrase Inhibitors ◆ Prostaglandin Agonists
Onychomychosis Antifungals (Oral)	Lipotropics: Cholesterol Absorption Inhibitors
Topical Immunomodulators	Long-Acting Opioids
	Macrolides / Ketolides
Urinary Tract Antispasmodics	Pegylated Interferons
	Quinolones: Second and Third Generation
	Ribavirins, Oral
December 2004	*September 2004*
Hypoglycemics, Oral: ◆ Alpha-Glucosidase Inhibitors ◆ Biguanides and Biguanides Combination Products ◆ Meglitinides ◆ Thiazolidinediones ◆ Sulfonylureas, Second Generation	Antihistamines: ◆ Second Generation and Decongestant Combination
	Anti-Migraine Medications: ◆ Serotonin 5HT-1 Receptor Agonists
	Beta Adrenergic Agents: ◆ Short-Acting Inhalers/Inhalation Devices ◆ Long-Acting Metered Dose Inhalers ◆ Short-Acting Nebulizers
Insulins	Inhaled and Nasal Steroids: Glucocorticoids ◆ Inhaled and Inhaled Devices ◆ Glucocorticoids and Long-Acting Beta-2 Adrenergics ◆ Intranasal Steroids
Lipotropics: ◆ Statins ◆ Cholesterol Absorption Inhibitors	Leukotriene Receptor Antagonists
	Sedative Hypnoticsl: ◆ Non-Barbiturates
August 2004	*May 2004*
ACE Inhibitor and Calcium Channel Blocker Combinations	Angiotensin Converting Enzyme (ACE) Inhibitors
Anti-Hyperkinesis Drugs	Angiotensin Receptor Blockers (ARB's)
Beta Blockers	Biphosphonates for Osteoporosis

PDL Therapeutic Classes That Comprise The PDL *FIRST HEALTH CLINICAL CALL CENTER: 866-247-1181 (toll-free)*	
Calcium Channel Blockers	Gastrointestinals: ◆ Histamine-2 Receptor Antagonists ◆ Proton Pump Inhibitors (PPI's)
Non-Steroidal Anti-Inflammatory Drugs (NSAID's)	Cephalosporins: 2nd and 3rd Generations

If a pharmacy claim is submitted for a PA-required product that has not been approved for Medicaid reimbursement, the claim will reject. If this occurs, the pharmacist should contact the prescriber so that a determination may be made regarding whether a drug *not* requiring PA may be clinically appropriate for the patient.

Additionally, it may be beneficial for the pharmacist to advise the patient of the prior authorization requirement. If alternative therapy (a drug *not* requiring PA) is deemed inappropriate by the prescriber, it will be necessary for the *prescriber or the prescriber's designated office personnel* to request prior authorization for that product by contacting the First Health Clinical Call Center. Therefore, since the PA request must be originated by the prescriber or his/her designated agent, the First Health Clinical Call Center telephone number is reserved for use by health care professionals and should not be furnished directly to beneficiaries. (First Health's beneficiary call center telephone number for questions regarding Pharmacy Services-related issues is 1-800-834-2680.)

Questions regarding this bulletin should be directed to the Department of Pharmacy Services at (803) 898-2876.

Robert M. Kerr
Director

RMK/bgav

Attachments

NOTE: The most current version of the provider manual is maintained on the DHHS Web site at www.dhhs.state.sc.us. [From the DHHS home page, scroll down and click on the link for Resource Library; next, click on the link for Manuals, and scroll down to the listings located beneath the heading Service Providers.]

Should you wish to order a printed replacement section for your provider manual, or a replacement compact disc containing a copy of the manual in Portable Document Format

(PDF), please call South Carolina Medicaid Provider Outreach at (803) 264-9609. Charges for printed manuals are based on actual costs of printing and mailing.

To receive Medicaid bulletins by email or to sign up for Electronic Funds Transfer of your Medicaid payment, please go to the following link for instructions:
http://www.dhhs.state.sc.us/ResourceLibrary/E-Bulletins.htm

South Carolina Department of Health and Human Services Preferred Drug List

Products Within PDL Therapeutic Classes Are Available Without Prior Authorization (PA)

{Non-listed products belonging to therapeutic classes on the PDL require PA}

Listing Updated: April 2005

ANALGESIC

NSAID's

Diclofenac Potassium
Diclofenac Sodium
Etodolac
Fenoprofen
Flurbiprofen
Ibuprofen
Indomethacin
Indomethacin SR
Ketoprofen
Ketoprofen ER
Ketorolac
Meclofenamate Sod.
Nabumetone
Naproxen
Naproxen Sodium
Oxaprozin
Piroxicam
Sulindac
Tolmetin Sodium

OPIOIDS, EXTENDED RELEASE

Avinza®
Duragesic® Patch
Kadian®
Morphine Sulfate ER✳
✳ Generic for MS Contin®.

ANTI-INFECTIVE

ANTIBACTERIALS

Cephalosporins, 2nd Generation

Ceftin® Suspension
Cefuroxime Tablets
Cefzil ® Tablets
Cefzil ® Suspension

Cephalosporins, 3rd Generation

Omnicef® Capsules
Omnicef® Suspension
Spectracef® Tablets

Macrolides / Ketolides

Biaxin®
Biaxin XL®
EryPed®
Ery-Tab®
Erythromycin Base
Erythromycin Estolate
Erythromycin Ethylsuc.
Erythromycin Stearate
Erythrocin Stearate
Erythromycin & Sulfisox.
Zithromax®

Quinolones, 2nd and 3rd Generation

Ciprofloxacin
Levaquin®
Ofloxacin
Tequin®

ANTIFUNGALS, ORAL

Onychomycosis Agents

Gris-Peg®
Grifulvin V®
Lamisil®

ANTIVIRALS, ORAL

Herpes Antivirals

Acyclovir
Famvir®
Valtrex®

CARDIOVASCULAR

ACE INHIBITORS (ACEI)

Captopril
Enalapril
Enalapril/HCTZ
Lisinopril
Lisinopril/HCTZ
Aceon®✳
✳ Generic agents should be considered first-line when appropriate.

ACEI, CALCIUM CHANNEL BLOCKER COMBINATIONS

Lotrel®
Tarka®

ANGIOTENSIN RECEPTOR BLOCKERS

Avapro®
Avalide®
Benicar®
Benicar HCT®
Diovan®
Diovan HCT®

BETA BLOCKERS

Acebutolol
Atenolol
Atenolol/Chlorthalidone
Betaxolol
Bisoprolol Fumarate
Bisoprolol/HCTZ
Labetolol
Metoprolol Tartrate
Nadolol
Pindolol
Propranolol
Propranolol/HCTZ
Sotalol
Timolol
Coreg®✳
✳ The use of Coreg® should be reserved for the treatment of hypertension in the presence of heart failure.

CALCIUM CHANNEL BLOCKERS, DIHYDROPYRIDINE

Dynacirc®
Dynacirc CR®
Nicardipine
Nefedical XL®
Nifedipine ER
Nifedipine SA
Norvasc®
Plendil ®

CALCIUM CHANNEL BLOCKERS, NON-DIHYDROPYRIDINES

Cartia XT®
Diltia XT®
Diltiazem
Diltiazem ER
Diltiazem XR
Taztia XT®
Verapamil
Verapamil ER
Verapamil SR

LIPOTROPICS

Statins

Advicor®
Altoprev®
Crestor®
Lescol ®
Lescol XL®
Lipitor®
Lovastatin
Pravachol ®
Zocor®

Cholesterol Absorption Inhibitors

Vytorin®
Zetia®

CENTRAL NERVOUS SYSTEM

ALZHEIMER'S AGENTS

Cholinesterase Inhibitors

Aricept®
Exelon®
Reminyl®

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ANTI-MIGRAINE AGENTS

Selective Serotonin Agonists

Amerge®
Axert®
Imitrex® Tablets,
Imitrex® Injection
Imitrex® Nasal Spray
Maxalt®
Maxalt-MLT®
Relpax®
Zomig® Tablets
Zomig-ZMT®
Zomig® Nasal Spray
✳ See the listing at http://southcarolina.com *for the quantity limits for this class. (Click on Providers, then Documents, then Pharmacy Quantity Limits.)*

ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS

Amphetamine Salt Combination
Dextroamphetamine
Dextroamphetamine SR
Metadate CD®
Metadate ER®
Methylin®
Methylin ER®
Methylphenidate
Methylphenidate SR
Ritalin LA®✳
Adderall XR®✳
Concerta®✳
✳ *Generic agents considered "first-line" when appropriate.*

SEDATIVE/HYPNOTICS, NON-BARBITURATES

Temazepam
Triazolam
Sonata®✳
Restoril ® 7.5 mg✳
✳ *Generics should be considered first-line when appropriate.*

ENDOCRINE AND METABOLIC

ANTI-DIABETICS

Alpha-Glucosidase Inhibitors

Glyset®
Precose®

Biguanides

Glucophage XR® 750 mg
Metformin
Metformin ER® 500 mg

Biguanide Combination

Avandamet®
Glucovance®
Glyburide/Metformin

Insulins

Novolin® L
Novolin® N
Novolin® R
Novolin® 70/30
Novolog®
Novolog® 70/30
Humulin® U
Humalog® 75/25
Humulin® 50/50
Lantus®

Meglitinides

Starlix®

Sulfonylureas, 2nd Generation

Glipizide
Glipizide ER
Glyburide
Glyburide Micronized

Thiazolidinediones

Actos®
Avandia®

BIPHOSPHONATES - OSTEOPOROSIS

Actonel®
Fosamax®

GASTROINTESTINAL

ANTI-EMETICS

Serotonin Receptor Antagonists

Kytril ®
Zofran®
Zofran ODT®

Histamine-2 Receptor Antagonists

Famotidine
Ranitidine
Zantac® Syrup

Proton Pump Inhibitors✳

Nexium®
Protonix®
Prilosec OTC®
✳ *Clinical criteria are in effect for this class. Once criteria are met, the PPI's listed on the PDL will be preferred. Patients* ***age 12 and younger*** *may receive the PPI, Prevacid®, without PA.*

GENITOURINARY

ANTISPASMODICS

Detrol LA®
Enablex®
Oxybutynin
Oxytrol ®

IMMUNOLOGIC

IMMUNOMODULATORS, ORAL

Hepatitis C Therapy, Pegylated Interferons

Pegasys®
Pegasys® Conv. Pack
Peg-Intron®
Peg-Intron® Redipen™

Hepatitis C Therapy, Ribavirins

Copegus®
Rebetol ®

IMMUNOMODULATORS, TOPICAL

Elidel® ✳
Protopic® ✳
✳ *Prescribers are reminded to use these agents as advised by the respective manufacturers and reserve for only those patients who have failed traditional eczema therapy.*

OPHTHALMICS

GLAUCOMA THERAPY

Alpha-2 Adrenergics

Brimonidine Tartrate

Beta Blocker

Betaxolol HCl
Carteolol HCl
Levobunolol HCl
Metipranolol
Timolol Maleate
Timolol Maleate gel-forming

Carbonic Anhydrase Inhibitors

Azopt®
Cosopt®
Trusopt®

Prostaglandin Agonists

Lumigan®
Travatan®
Xalatan®

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RESPIRATORY

ANTI-CHOLINERGICS

Atrovent®
Combivent®
Spiriva®

ANTIHISTAMINE, 2nd GENERATION AND DECONGESTANT COMBINATIONS

Loratadine *OTC*
Loratadine-D *OTC*
Zyrtec® Syrup✳
✳ *For patients less than 2 years of age*

BETA ADRENERGIC DEVICES, SHORT-ACTING INHALERS, INHALATION

Albuterol

BETA ADRENERGIC DEVICES, LONG-ACTING METERED DOSE INHALERS

Serevent®✳
✳ *For maintenance therapy only*

BETA ADRENERGIC AGENTS, SHORT-ACTING NEBULIZERS

Albuterol
Metaproterenol
Xopenex®✳
✳ *Generic agents should be considered as first-line therapy when appropriate*

GLUCOCORTICOIDS

Inhaled, Inhalation Devices

Azmacort®
Flovent®
Qvar®

Intranasal Steroids

Flonase®
Nasarel ®
Nasonex®
Rhinocort AQ®

Glucocorticoids and Long-Acting Beta-2 Adrenergics

Advair® Diskus

Leukotriene Receptor Antagonists

Accolate®
Singulair®✳
✳ *No PA is required if used in the treatment of asthma with inhaled steroid or beta agonist therapy or after trial of a second generation antihistamine or nasal steroid therapy.*

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A

ACCOLATE
ACEBUTOLOL
ACEON
ACTONEL
ACTOS
ACYCLOVIR
ADDERALL XR
ADVAIR DISKUS
ADVICOR
ALBUTEROL INHALATION
ALBUTEROL NEBULIZER
ALTOPREV
AMERGE
AMPHETAMINE SALT COMBINATION
ARICEPT
ATENOLOL
ATENOLOL/CHLORTHALIDONE
ATROVENT
AVALIDE
AVANDAMET
AVANDIA
AVAPRO
AVINZA
AXERT
AZMACORT

B

BENICAR
BENICAR HCT
BETAXOLOL
BETAXOLOL HCL OPHTHALMIC
BIAXIN
BIAXIN XL
BISOPROLOL FUMARATE
BISOPROLOL/HCTZ
BRIMONIDINE TARTRATE OPHTH.

C

CAPTOPRIL
CARTEOLOL HCL OPHTHALMIC
CARTIA XT
CEFTIN SUSPENSION
CEFZIL SUSPENSION
CEFZIL TABLETS
CIPROFLOXACIN
COMBIVENT
CONCERTA
COPEGUS
COREG
COSOPT
CRESTOR
CEFUROXIME TABLETS

D

DETROL LA
DEXTROAMPHETAMINE
DEXTROAMPHETAMINE SR
DICLOFENAC POTASSIUM
DICLOFENAC SODIUM
DILTIA XT
DILTIAZEM
DILTIAZEM XR
DIOVAN
DIOVAN HCT
DURAGESIC PATCH
DYNACIRC
DYNACIRC CR

E

ELIDEL
ENABLEX
ENALAPRIL
ENALAPRIL/HCTZ
ERYPED
ERY-TAB
ERYTHROCIN STEARATE
ERYTHROMYCIN BASE
ERYTHROMYCIN ESTOLATE
ERYTHROMYCIN ETHYLSUCCINATE
ERYTHROMYCIN STEARATE
ERYTHROMYCIN WITH SULFISOXAZOLE
ETODOLAC
EXELON

F

FAMOTIDINE
FAMVIR
FENOPROFEN
FLONASE
FLOVENT
FLURBIPROFEN
FOSAMAX

G

GLIPIZIDE
GLIPIZIDE ER
GLUCOPHAGE XR 750 MG
GLUCOVANCE
GLYBURIDE
GLYBURIDE MICRONIZED
GLYBURIDE/METFORMIN
GLYSET
GRIFULVIN V
GRIS-PEG

H

HUMALOG 75/25
HUMULIN 50/50
HUMULIN U

I

IBUPROFEN
IMITREX INJECTION
IMITREX NASAL SPRAY
IMITREX TABLETS
INDOMETHACIN
INDOMETHACIN SR

J

K

KADIAN
KETOPROFEN
KETOPROFEN ER
KETOROLAC
KYTRIL

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L

LABETOLOL
LAMISIL
LANTUS
LESCOL
LESCOL XL
LEVAQUIN
LEVOBUNOLOL HCL OPHTHALMIC
LIPITOR
LISINOPRIL
LISINOPRIL/HCTZ
LORATADINE OTC
LORATADINE-D OTC
LOTREL
LOVASTATIN
LUMIGAN

M

MAXALT
MAXALT-MLT
MECLOFENAMATE SODIUM
METADATE CD
METADATE ER
METAPROTERENOL NEBULIZER
METFORMIN
METFORMIN ER 500 MG
METHYLIN
METHYLIN DR
METHYLPHENIDATE
METHYLPHENIDATE SR
METIPRANOLOL OPHTHALMIC
METOPROLOL TARTRATE
MORPHINE SULFATE ER

N

NABUMETONE
NADOLOL
NAPROXEN
NAPROXEN SODIUM
NASAREL
NASONEX
NIFEDICAL XL
NEXIUM
NICARDIPINE
NIFEDIPINE ER
NIFEDIPINE SA
NORVASC
NOVOLIN 70/30
NOVOLIN L
NOVOLIN N
NOVOLIN R
NOVOLOG
NOVOLOG 70/30

O

OFLOXACIN
OMNICEF CAPSULES
OMNICEF SUSPENSION
OXAPROZIN
OXYBUTININ
OXYTROL

P

PEGASYS
PEGASYS CONVENIENCE PACK
PEG-INTRON
PEG-INTRON REDIPEN
PINDOLOL
PIROXICAM
PLENDIL
PRAVACHOL
PRECOSE
PREVACID (< AGE 12)
PRILOSEC OTC
PROPRANOLOL
PROPRANOLOL/HCTZ
PROTONIX
PROTOPIC

Q

QVAR

R

RANITIDINE
REBETOL
RELPAX
REMINYL
RESTORIL
RHINOCORT AQ
RITALIN LA

S

SEREVENT
SINGULAIR
SONATA
SOTALOL
SPECTRACEF TABLETS
SPIRIVA
STARLIX
SULINDAC

T

TARKA
TAZTIA XT
TEMAZEPAM
TEQUIN
TIMOLOL
TIMOLOL MALEATE GEL-FORMING
TIMOLOL MALEATE OPHTHALMIC
TOLMETIN SODIUM
TRAVATAN
TRIAZOLAM
TRUSOPT

U

V

VALTREX
VERAPAMIL
VERAPAMIL ER
VERAPAMIL SR
VYTORIN

W

X

XALATAN
XOPENEX

Y

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Z

ZANTAC SYRUP
ZETIA
ZITHROMAX
ZOCOR
ZOFRAN
ZOFRAN ODT
ZOMIG
ZOMIG NASAL SPRAY
ZOMIG-ZMT
ZYRTEC SYRUP (< AGE 2)

SOUTH CAROLINA MEDICAID PROGRAM

PRIOR AUTHORIZATION REQUEST

PRESCRIBER:

NAME: _____
FIRST LAST

DEA LICENSE # _____

PHONE # (_____) _____

FAX # (_____) _____

BENEFICIARY:

NAME: _____
FIRST LAST

MEDICAID # / SSN: _____

DATE OF BIRTH: _____ **SEX:** _____

REQUEST DATE: _____

PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM: _____

PHARMACY: _____ **PHONE:** ( ) _____

PRIOR AUTHORIZATION REQUESTED FOR: (Please check appropriate prior authorization type)

☐ **Anti-Ulcer Therapy**	☐ **Orlistat** (please include information regarding height, weight, diet plans, nutritional counseling, etc., with all orlistat requests)	☐ **Preferred Drug List**
☐ **COX-2 Inhibitor Therapy**	☐ **OxyContin®**	☐ **Quantity Limits**
☐ **Brand Name NSAID Therapy**	☐ **Panretin®/Targretin®**	**Other:** _____
☐ **Erectile Dysfunction Therapy**		*"Brand Medically Necessary" requests require MedWatch form – please submit those requests on appropriate form
☐ **Growth Hormone**		

DRUG NAME	DOSE	STRENGTH	LENGTH OF THERAPY

DIAGNOSIS: _____

DIAGNOSTIC PROCEDURES AND FINDINGS (please list dates): _____

_____

MEDICAL JUSTIFICATION FOR PRODUCT USE: _____

_____

PRESCRIBER'S SIGNATURE AND SPECIALTY:

_____

FIRST HEALTH SERVICES USE ONLY: ☐ **APPROVED** ☐ **DENIED**

DATE: _____/_____/_____

MAP RPh/TECH: _____

NDC: _____

COMMENTS: _____

_____

_____

SUBMIT REQUESTS TO: **FIRST HEALTH SERVICES** **FAX: (888) 603-7696**
All Fax requests will be processed in one business day. To check on the status you may call: TELEPHONE: (866) 247-1181

Revised: July 2004