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

July 11, 2005

DEN	*05-04*
HH-HOSP	*05-05*
HOS-IP-GEN	*05-10*
HOS-OP	*05-11*
MC-DHEC	*05-10*
MC-FQHC	*05-10*
MC-MCHC	*05-09*
MC-RHC	*05-10*
MCRC-MHC	*05-05*
PHARM	*05-06*
PHY-ALG	*05-09*
PHY-ANES	*05-09*
PHY-CARD	*05-09*
PHY-DERM	*05-09*
PHY-ENT	*05-09*
PHY-ER	*05-09*
PHY-MSP-CBP	*05-09*
PHY-MSP-HBP	*05-09*
PHY-OPHT	*05-09*
PHY-PATH	*05-09*
PHY-PC-FP/GP	*05-12*
PHY-PC-GER	*05-09*
PHY-PC-INT	*05-11*
PHY-PC-NEO	*05-10*
PHY-PC-OG	*05-12*
PHY-PC-PED	*05-11*
PHY-PC-PED/SUB	*05-11*
PHY-PS	*05-09*
PHY-RAD	*05-09*
PHY-S	*05-09*
PHY-SPEC	*05-09*
PHY-SURG	*05-09*
POD	*05-06*

MEDICAID BULLETIN

TO: **Providers Indicated**

SUBJECTS:
I. Non-Coverage Of Erectile Dysfunction Drugs For Impotence
II. South Carolina Medicaid Preferred Drug List

I. Non-Coverage of Erectile Dysfunction Drugs For Impotence

To ensure the best use of limited Medicaid dollars, effective with dates of service September 1, 2005, the South Carolina Department of Health and Human Services (DHHS) will no longer reimburse for erectile dysfunction (E/D) drugs (e.g., Viagra®, Cialis®, Levitra®, etc.) when prescribed for any Medicaid beneficiary to treat impotence. Additionally, all approvals for previously prior authorized E/D drugs for impotence will be terminated effective September 1, 2005.

II. South Carolina Medicaid Preferred Drug List

To ensure maximum clinical and cost effectiveness, South Carolina Medicaid's Preferred Drug List (PDL) has been revised. While no additional *therapeutic classes* have been added or deleted from the PDL, there are several additions/deletions of *specific drugs* within certain PDL therapeutic classes. Attached to this bulletin is a comprehensive listing of products within all therapeutic classes that comprise the South Carolina Medicaid PDL.

Upon initial implementation of the PDL changes noted below, pharmacists will observe soft edits [i.e., electronic messages received via point of sale] when pharmacy claims are submitted for products that will eventually require prior authorization (PA). This

period of soft editing will occur for approximately four to six weeks. 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.

Effective with dates of service September 6, 2005, "new" hard edits will be activated (i.e., pharmacy claims without PA approval will deny) for "newly designated" non-preferred products within the therapeutic classes listed below.

REVISED PDL DRUG *CLASSES:* Effective September 6, 2005	
1) Angiotensin II Receptor Blockers	**4)** Glucocorticoids: Intranasal Steroids
2) Antihistamines: Second Generation and Decongestant Combinations	**5)** Sedative/Hypnotics (Non-Barbiturate)
3) Biphosphonates For Osteoporosis	

*The **complete PDL** (attached to this bulletin) includes the following changes:*

REVISED PDL *DRUGS:* Effective September 6, 2005		
PREFERRED		**NON-PREFERRED**
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)*		
Cozaar®	Added to PDL	*Atacand®*
Diovan®	Remains on PDL	*Atacand HCT®*
Diovan HCT®	Remains on PDL	*Avalide®*
Hyzaar®	Added to PDL	*Avapro®*
Micardis®	Added to PDL	*Benicar®*
Micardis HCT®	Added to PDL	*Benicar HCT®*
Teveten®	Added to PDL	
Teveten HCT®	Added to PDL	
Please note that patients currently maintained on non-preferred ARBs are "grandfathered" and may continue their current ARB therapy without PA.		
ANTIHISTAMINES: SECOND GENERATION AND DECONGESTANT COMBINATIONS		
Loratadine OTC–Tablets, Rapid Dissolve, Syrup	Remains on PDL	*Alavert®*
Loratadine-D OTC	Remains on PDL	*Clarinex®*
Allegra®	Added to PDL	*Claritin D®*
Allegra-D®	Added to PDL	*Claritin®*
Zyrtec® (all formulations)	Added to PDL	
Zyrtec D®	Added to PDL	
BIPHOSPHONATES USED FOR OSTEOPOROSIS		
Fosamax®	Remains on PDL	*Actonel®*
		Boniva®
		Fosamax Plus D®
GLUCOCORTICOIDS: INTRANASAL STEROIDS		
Flonase®	Remains on PDL	*Beconase AQ®*
Nasacort AQ®	Added to PDL	*Flunisolide*
Nasonex®	Remains on PDL	*Nasacort®*
		Nasarel®
		Rhinocort AQ®
		Tri-Nasal®

REVISED PDL *DRUGS:* Effective September 6, 2005		
PREFERRED		**NON-PREFERRED**
SEDATIVE/HYPNOTICS (NON-BARBITURATE)		
Ambien®*	Added to PDL	*Doral®*
Restoril® 7.5 mg*	Remains on PDL	*Estazolam (all brands, formulations)*
Temazepam	Remains on PDL	*Flurazepam (all brands, formulations)*
		***Lunesta®*
		Restoril® 15mg, 30mg
		Somnote®
		Sonata®
		Triazolam (all brands, formulations)
** Generic agents should be considered "first-line" when appropriate.* *** Lunesta® is non-preferred; however, no PA is required if the patient's previous ninety days' history indicates use of one of the preferred agents.*		

Prescribers are strongly encouraged to write prescriptions for "preferred" products. However, if a prescriber deems that the patient's clinical status necessitates therapy with a PA-required drug, the prescriber (or his/her designated office personnel) is responsible for initiating the prior authorization request. A prospective, approved PA request will prevent rejection of prescription claims at the pharmacy due to the PA requirement.

All PA requests should be telephoned or submitted by fax to the First Health Clinical Call Center by the prescriber or the prescriber's designated office personnel. The toll-free telephone and fax numbers for the Clinical Call Center are 866-247-1181 and 888-603-7696, respectively. 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; providers may furnish the beneficiary call center telephone number to Medicaid beneficiaries *for Pharmacy Services-related issues only*.)

A pharmacy claim submitted for a PA-required product that has not been approved for Medicaid reimbursement 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 is clinically appropriate for the patient.

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

/s/

Robert M. Kerr
Director

RMK/bgav

Attachments

NOTE: The most current version of the provider manual is maintained on the SCDHHS Web site at www.dhhs.state.sc.us. [On the SCDHHS home page, click on the Provider Manuals link listed under the heading 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 that comprise the PDL require PA}

{Note that ALL therapeutic classes are not included on the PDL.}

Listing Updated: July 2005

ANALGESIC

NSAID's

Diclofenac Potassium
Diclofenac Sodium
Diflunisal
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 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® *(all forms)*
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✳

Cozaar®
Diovan®
Diovan HCT®
Hyzaar®
Micardis®
Micardis HCT®
Teveten
Teveten HCT®
✳ *Patients maintained on non-preferred ARBs are "grandfathered" (i.e., current therapy may be continued without PA).*

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 and SA
Norvasc®
Plendil ®

CALCIUM CHANNEL BLOCKERS, NON-DIHYDROPYRIDINES

Cartia XT®
Diltia XT®
Diltiazem
Diltiazem ER and 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®
Razadyne®

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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
Restoril ® 7.5 mg✳
Ambien®✳
✳ *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

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 ®

IMMUNOLOGICS

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 Blockers

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

Carbonic Anhydrase Inhibitors

Azopt®
Cosopt®
Trusopt®

Prostaglandin Agonists

Lumigan®
Travatan®
Xalatan®

First Health Clinical Call Center
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RESPIRATORY

ANTI-CHOLINERGICS

Atrovent®
Combivent®
Spiriva®

ANTIHISTAMINES, 2nd GENERATION AND DECONGESTANT COMBINATIONS

Allegra®
Allegra-D®
Loratadine *OTC (Tabs, Rapid Dissolve, Syrup)*
Loratadine-D *OTC*
Zyrtec® *(all formulations)*
Zyrtec D®

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®
Nasacort AQ®
Nasonex®

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
ACTOS
ACYCLOVIR
ADDERALL XR
ADVAIR DISKUS
ADVICOR
ALBUTEROL INHALATION
ALBUTEROL NEBULIZER
ALLEGRA
ALLEGRA-D
ALTOPREV
AMBIEN
AMERGE
AMPHETAMINE SALT COMBINATION
ARICEPT
ATENOLOL
ATENOLOL/CHLORTHALIDONE
ATROVENT
AVANDAMET
AVANDIA
AVINZA
AXERT
AZMACORT

B

BETAXOLOL
BETAXOLOL HCL OPHTHALMIC
BIAXIN (ALL FORMULATIONS)
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
COZAAR
CRESTOR
CEFUROXIME TABLETS

D

DETROL LA
DEXTROAMPHETAMINE
DEXTROAMPHETAMINE SR
DICLOFENAC POTASSIUM
DICLOFENAC SODIUM
DIFLUNISAL
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
HYZAAR

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 (ALL FORMS)
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
MICARDIS
MICARDIS HCT
MORPHINE SULFATE ER

N

NABUMETONE
NADOLOL
NAPROXEN
NAPROXEN SODIUM
NASACORT AQ
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
RAZADYNE
REBETOL
RELPAX
RESTORIL (7.5 MG STRENGTH ONLY)
RITALIN LA

S

SEREVENT
SINGULAIR
SOTALOL
SPECTRACEF TABLETS
SPIRIVA
STARLIX
SULINDAC

T

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

U

V

VALTREX
VERAPAMIL
VERAPAMIL ER
VERAPAMIL SR
VYTORIN

W

X

XALATAN
XOPENEX

Y

First Health Clinical Call Center
Telephone: 866-247-1181 (toll-free)
Fax: 888-603-7696 (toll-free)

Z

ZANTAC SYRUP
ZETIA
ZITHROMAX
ZOCOR
ZOFRAN
ZOFRAN ODT
ZOMIG
ZOMIG NASAL SPRAY
ZOMIG-ZMT
ZYRTEC (ALL FORMULATIONS)
ZYRTEC D

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**
- ☐ **COX-2 Inhibitor Therapy**
- ☐ **Orlistat** (Include information regarding height, weight, diet plans, nutritional counseling, etc., with all orlistat requests.)
- ☐ **Panretin®/Targretin®**
- ☐ **Preferred Drug List**
- ☐ **Quantity Limits**
- ☐ **Sildenafil for Pulmonary Arterial Hypertension**

Other: ______________________________

NOTE:

"Brand Medically Necessary" PA requests require a *South Carolina Medicaid MedWatch form.*

"Growth Hormone" PA requests require a *Growth Hormone request form.*

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 2005