

SOUTH CAROLINA MEDICAID PROGRAM
PRIOR AUTHORIZATION REQUEST

PRESCRIBER: NAME: _____ (FIRST) (LAST) National Provider ID # _____ PHONE # (____) _____ FAX # (____) _____ PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM: _____	BENEFICIARY: NAME: _____ (FIRST) (LAST) MEDICAID #: _____ DATE OF BIRTH: ___/___/___ SEX: <input type="checkbox"/> M <input type="checkbox"/> F REQUEST DATE: ___/___/___
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PHARMACY: _____ **PHONE:** (____) _____

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

<input type="radio"/> Orlistat (please include information regarding height, weight, diet plans, nutritional counseling, etc., with all orlistat requests)	<input type="radio"/> Quantity Limits <input type="radio"/> PDE5 Inhibitor for Pulmonary Arterial Hypertension Other: _____	NOTE: "Brand Medically Necessary" PA requests require a <i>South Carolina MedWatch form</i> . "Growth Hormone" PA requests require a <i>Growth Hormone request form</i> .
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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: _____

<u>FIRST HEALTH SERVICES USE ONLY:</u> DATE: ___/___/___ MAP RPh/TECH: _____ NDC: _____	<input type="radio"/> APPROVED <input type="radio"/> DENIED COMMENTS: _____ _____ _____
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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**
WEB REQUESTS: PA's may be requested on-line see the following website for details: <http://southcarolina.fhsc.com/>