

SOUTH CAROLINA MEDICAID - MEDWATCH

A. Patient Information			
1. Patient Name: _____ <small>(First) (Last)</small>		2. SC Medicaid Recipient's ID #: _____	
3. Date of Birth (mm/dd/yy): ____/____/____	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Weight _____ lbs OR _____ kgs	6. Request Date (mm/dd/yy): ____/____/____
B. Adverse Event or Product Problem			
1. <input type="checkbox"/> Adverse Event ~OR~ (please refer to number 2)		2. Outcomes attributed to adverse event (<i>check all that apply</i>) <input type="checkbox"/> Congenital Anomaly <input type="checkbox"/> Death (Date: ____/____/____) <input type="checkbox"/> Disability <input type="checkbox"/> Hospitalization (initial or prolonged) <input type="checkbox"/> Life-threatening <input type="checkbox"/> Required intervention to prevent permanent impairment/damage <input type="checkbox"/> Other: _____	
3. Date of Event (mm/dd/yy): ____/____/____		4. Date of this Report (mm/dd/yy): ____/____/____	
5. Describe Event or Problem:			
6. Relevant tests / laboratory data, including dates:			
7. Other relevant history, including pre-existing medical conditions (e.g., allergies, pregnancy, smoking and alcohol use, hepatic/renal dysfunction, etc.)			
C. Suspect Medication(s)			
1. Drug Name: _____	2. Strength: _____	3. Therapy Dates (if unknown, give duration) From: ____/____/____ To: ____/____/____ (Or, give best estimate)	
4. Diagnosis for Use (indication): _____	5. Event abated after use stopped or dose reduced? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't Apply	6. Lot # (if known): _____	
7. Exp. Date (if known): ____/____/____	8. Event reappeared after reintroduction? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't Apply	9. NDC # (for product problems only): _____	
10. Concomitant medical products and therapy dates (exclude treatment of event):			
D. Prescribing Physician			
Name: _____	SC Medical License # (not DEA #): _____	Telephone #: (____) _____ - _____	FAX #: (____) _____ - _____
Signature of Prescriber: _____			
E. Reporter			
1. Name, Address and Phone #:			
2. Health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No	3. Occupation:	4. Also reported to: <input type="checkbox"/> Distributor <input type="checkbox"/> Manufacturer <input type="checkbox"/> User Facility	If you do NOT want your identity disclosed to the manufacturer, place an "X" in this box: <input type="checkbox"/>

Pharmacy Fax Number (if known): (____) _____ - _____

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/>