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Prime THERAPEUTICS

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

South Carolina Medicaid
MedWatch Form

Fax this form to (888) 603-7696 **Telephone: (866) 247-1181**

Date of Request: _____ **Pharmacy fax number:** _____

PATIENT INFORMATION

Patient Last Name: _____ Patient First Name: _____

SC Medicaid Recipient ID: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female Weight: _____ lbs **OR** _____ kgs

PRESCRIBING PHYSICIAN INFORMATION

Prescriber Last Name: _____ Prescriber First Name: _____

SC Medical License (not DEA): _____

Telephone: _____ Fax: _____

REPORTER INFORMATION

Reporter Last Name: _____ Reporter First Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Health professional: ☐ Yes ☐ No

Occupation: _____ Reported to: ☐ Distributor ☐ Manufacturer ☐ User facility

☐ Select if you do **NOT** want your identity disclosed to the manufacturer

ADVERSE EVENT OR PRODUCT PROBLEM

1. Did an adverse event occur? (**OR** see question 2)

   ☐ Yes ☐ No

   a. **If yes,** specify date of adverse event: _____

2. Was there an outcome attributed to an adverse event?

   ☐ Yes ☐ No

   a. **If yes**, select outcomes attributed to adverse event (check all that apply):

   ☐ Congenital anomaly

   ☐ Death Specify date of death: _____

   ☐ Disability

   ☐ Hospitalization (initial or prolonged)

   ☐ Life-threatening

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Patient's Full Name: _____

☐ Required intervention to prevent permanent impairment/damage

☐ Other (specify): _____

3. Specify date of this report: _____

4. Describe event or problem:

5. List relevant tests/laboratory dates:

6. List other relevant history, including pre-existing medical conditions (e.g., allergies, pregnancy, smoking and alcohol use, hepatic/renal dysfunction, etc.):

SUSPECT MEDICATIONS

Drug Name: _____ Drug Strength: _____

Therapy dates (if unknown give duration or best estimate): _____ to _____

Diagnosis for use (indication): _____

Did the event abate after use stopped or dose reduced: ☐ Yes ☐ No ☐ Doesn't apply

Lot number (if known): _____ Expiration date (if known): _____

Did the event reappear after reintroduction: ☐ Yes ☐ No ☐ Doesn't apply

NDC number (for product problems only): _____

Specify concomitant medical products and therapy dates (exclude treatment of event):

Prescriber Signature: _____ Date: _____
(required)

All fax requests will be processed in one business day. Contact us by phone for status inquiries.

Submit requests to:

Prime Therapeutics Management LLC

Fax: 888-603-7696

Phone: 866-247-1181