# SOUTH CAROLINA MEDICAID - MEDWATCH

## A. Patient Information

| | | | |
|---|---|---|---|
| 1. Patient Name: _____ (First) (Last) | | 2. SC Medicaid Recipient's ID #: _____ | |
| 3. Date of Birth (mm/dd/yy): _____/_____/_____ | 4. Sex ☐ Male ☐ Female | 5. Weight _____ lbs OR _____ kgs | 6. Request Date (mm/dd/yy): _____/_____/_____ |

## B. Adverse Event or Product Problem

| | |
|---|---|
| 1. ☐ Adverse Event ~OR~ (please refer to number 2) | 2. Outcomes attributed to adverse event (*check **all** that apply*)<br>☐ Congenital Anomaly<br>☐ Death (Date: ____/____/____)<br>☐ Disability<br>☐ Hospitalization (initial or prolonged)<br>☐ Life-threatening<br>☐ Required intervention to prevent permanent impairment/damage<br>☐ 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)<br>From: ____/____/____ To: ____/____/____<br>(Or, give best estimate) |
| 4. Diagnosis for Use (indication):_____ | 5. Event abated after use stopped or dose reduced?<br>☐ Yes ☐ No ☐ Doesn't Apply | 6. Lot # (if known): _____ |
| 7. Exp. Date (if known): _____/_____/_____ | 8. Event reappeared after reintroduction?<br>☐ Yes ☐ No ☐ Doesn't Apply | 9. NDC # (for product problems only):<br>_____ |
| 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?<br>☐ Yes ☐ No | 3. Occupation: | 4. Also reported to:<br>☐ Distributor<br>☐ Manufacturer<br>☐ User Facility | If you do NOT want your identity disclosed to the manufacturer, place an "X" in this box: ☐ |

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

**SUBMIT REQUESTS TO: MAGELLAN MEDICAID ADMINISTRATION**
**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/**