Reset Save Print

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

South Carolina Medicaid Program

General Prior Authorization Request Form

Form must be complete, correct, and legible or the PA process can be delayed.

Request Date: ___ / ___ / _____

I. BENEFICIARY INFORMATION

First Name **Last Name**

Medicaid ID # **Date of Birth (MM/DD/YYYY)** / / **Sex** ☐ Male ☐ Female

II. PRESCRIBER'S INFORMATION

Prescriber's First Name **Prescriber's Last Name**

National Provider ID # (NPI) **Prescriber's Specialty**

Prescriber's Phone Number - - **Prescriber's Fax Number** - -

Prescriber's Office Staff Member Completing This Form

Pharmacy **Phone** - -

III. DRUG INFORMATION

Prior Authorization requested for the following: *(Please check appropriate PA type)*

☐ **Orlistat**
(Please include information regarding height, weight, diet plans, nutritional counseling, etc., with all orlistat requests)

☐ **Quantity Limits**

☐ **PDE5 Inhibitor for Pulmonary Arterial Hypertension**

☐ **Other:** _____

NOTE:

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

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

Drug Name: _____ **Dose:** _____ **Strength:** _____ **Duration:** _____

Diagnosis: _____ **ICD Code:** _____

Diagnostic Procedures and Findings *(please list dates)*: _____

Medical Justification for Product Use: _____

PRESCRIBER'S SIGNATURE: _____ **DATE:** _____

MAGELLAN RX MANAGEMENT USE ONLY: ☐ Approved ☐ Denied

Date: _____ **Comments:** _____

MAP RPh/Tech: _____

NDC: _____

Fax completed forms to Magellan Rx Management.
All fax requests will be processed in one business day.
To check the status of your request, please call or visit our website.
Revised: September 2015

Fax: 888-603-7696
Phone: 866-247-1181
Website: http://southcarolina.fhsc.com/

Magellan Rx MANAGEMENT℠