FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	02/2018
	Duplicate Remittance Advice Request Form	09/2017
	Claim Reconsideration Form	05/2018
	NCPCP Universal Claim Form Sample	
---	South Carolina Medicaid MedWatch	07/2010
---	Prior Authorization Request	10/2015
	Proton Pump Inhibitors Prior Authorization Request	12/2010
	Growth Hormone Prior Authorization Request – Adult Treatment	09/2015
	Growth Hormone Prior Authorization Request – Pediatric Treatment	09/2015
	Antipsychotics for Children Ages ≤ 6 Years	09/2015
	Prior Authorization Request – Hepatitis B	09/2015
	Prior Authorization Request – Hepatitis C	05/2010

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

CONFIDENTIAL COMPLAINT

SEND TO: DIRECTOR, DIVISION OF PROGRAM INTEGRITY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 100210, 1801 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202-3210

PROGRAM INTEGRITY

THIS REPORT IS DESIGNED FOR THE REPORTING OF POSSIBLE ABUSE BY MEDICAID PROVIDERS AND/OR RECIPIENTS. USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR COMPLAINT. PLEASE IDENTIFY YOURSELF AND WHERE YOU CAN BE REACHED FOR FUTURE REFERENCES. UNLESS OTHERWISE INDICATED, ALL INFORMATION SHOULD BE PRINTED OR TYPED.

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:	
NPI or MEDICAID PROVIDER ID: (if applicable)	MEDICAID RECIPIENT ID NUMBER: (if applicable)
ADDRESS OF SUSPECT:	LOCATION OF INCIDENT:
	DATE OF INCIDENT:
COMPLAINT:	

NAME OF PERSON REPORTING: (Please print)	SIGNATURE OF PERSON REPORTING:	DATE OF REPORT

ADDRESS OF PERSON REPORTING:	TELEPHONE NUMBER OF PERSON REPORTING:
	SIGNATURE: (SCDHHS Representative Receiving Report)

South Carolina Department of Health and Human Services
Form for Medicaid Refunds

Purpose: This form is to be used for all refund checks made to Medicaid. This form gives the information needed to properly account for the refund. If the form is incomplete, the provider will be contacted for the additional information.

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed. **Attach appropriate document(s) as listed in item 8.**

1. **Provider Name:** _____

2. **Medicaid Legacy Provider #** ☐☐☐☐☐☐
(Six Characters)

OR

3. **NPI#** ☐☐☐☐☐☐☐☐☐☐ **& Taxonomy** ☐☐☐☐☐☐☐☐☐☐

4. **Person to Contact:** _____ 5. **Telephone Number:** _____

6. **Reason for Refund:** [check appropriate box]

☐ Other Insurance Paid (please complete **a – f** below and attach insurance EOMB)
- **a** Type of Insurance: ( ) Accident/Auto Liability ( ) Health/Hospitalization
- **b** Insurance Company Name _____
- **c** Policy #:_____
- **d** Policyholder: _____
- **e** Group Name/Group: _____
- **f** Amount Insurance Paid:_____

☐ Medicare
- ( ) Full payment made by Medicare
- ( ) Deductible not due
- ( ) Adjustment made by Medicare

☐ Requested by DHHS (please attach a copy of the request)

☐ Other, describe in detail reason for refund:

_____
_____
_____
_____

7. **Patient/Service Identification:**

Patient Name	Medicaid I.D.# (10 digits)	Date(s) of Service	Amount of Medicaid Payment	Amount of Refund

8. **Attachment(s):** [Check appropriate box]

☐ Medicaid Remittance Advice (required)

☐ Explanation of Benefits (EOMB) from Insurance Company (if applicable)

☐ Explanation of Benefits (EOMB) from Medicare (if applicable)

☐ Refund check

Make all checks payable to: South Carolina Department of Health and Human Services
Mail to: SC Department of Health and Human Services
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355

DHHS Form 205 (01/08)

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: _____ Provider ID or NPI: _____

Contact Person: _____ Phone #: _____ Date: _____

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

_____ a. beneficiary has never been covered by the policy – close insurance.

_____ b. beneficiary coverage ended - terminate coverage (date) _____

_____ c. subscriber coverage lapsed - terminate coverage (date) _____

_____ d. subscriber changed plans under employer - new carrier is _____

- new policy number is _____

_____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax: 803-252-0870 **or** **Mail:** Post Office Box 101110, Columbia, SC 29211-9804

South Carolina Department of Health and Human Services
Duplicate Remittance Advice Request Form

Purpose: This form is to be used for all requests for duplicate remittance advices from South Carolina Medicaid. The form must be completed in its entirety in order to honor the request. If the form is incomplete, the form will be returned requesting the additional information.

Please contact the SCDHHS Medicaid Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for instructions on submission of your request.

1. Provider Name: _____

2. Medicaid Legacy Provider # _____ (Six Characters)

   NPI# _____ Taxonomy _____

3. Person to Contact: _____ Telephone Number: _____

4. Please list the date(s) of the remittance advice for which you are requesting a duplicate copy:
   _____
   _____
   _____
   _____
   _____

   Note: Remittance advices are available electronically through the Web Tool. Please check the Web Tool for the availability of the remittance advice date before submitting your request.

5. Street Address for delivery of request:

   Street: _____

   City: _____

   State: _____

   Zip Code: _____

6. Charges for duplicate remittance advice(s) are as follows:

   Request Processing Fee - $20.00

   Page(s) copied - .20 per page

I understand and acknowledge that a charge is associated with this request and will be deducted from my provider's payment by debit adjustment on a future remittance advice.

_____ _____

Authorizing Signature **Date**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Submit your Claim Reconsideration request to:

Fax: 1-855-563-7086
or
Mail: South Carolina Healthy Connections Medicaid
ATTN: Claim Reconsiderations
Post Office Box 8809
Columbia, SC 29202-8809

CLAIM RECONSIDERATION FORM

Instructions: Complete this form within 30 days of receipt of the remittance advice reflecting the denied claim, and attach all documentation in support of your request. A separate SCDHHS CR form is required for each claim control number (CCN). Allow up to 60 days for a written response. Claim disputes must first be initiated through the Provider Service Center (PSC). Enter the PSC Communication ID in the required field below. For questions, contact the PSC at 1-888-289-0709. **Note:** Timely filing guidelines apply.

Section 1: Beneficiary Information

Name (Last, First, MI): _____

Date of Birth: _____ Medicaid Beneficiary ID: _____

Section 2: Provider Information

Specify your affiliation: ☐ Physician ☐ Hospital ☐ Other (DME, Lab, Home Health Agency, etc.): _____

NPI: _____ Medicaid Provider ID: _____ Facility/Group/Provider Name: _____

Return Mailing Address: _____
Street or Post Office Box *State* *ZIP*

Contact: _____ Email: _____ Telephone #: _____ Fax #: _____

Section 3: Claim Information *(Only one CCN allowed per request.)*

Communication ID: _____ CCN: _____ Date(s) of Service: _____

Section 4: Claim Reconsideration Information

What area is your denial related to? (Please select below)

- ☐ Ambulance Services
- ☐ Autism Spectrum Disorder (ASD) Services
- ☐ Clinic Services
- ☐ Community Long Term Care (CLTC)
- ☐ Community Mental Health Services
- ☐ Department of Disabilities and Special Needs (DDSN) Waivers
- ☐ Durable Medical Equipment (DME)
- ☐ Early Intervention Services
- ☐ Enhanced Services
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Home Health Services
- ☐ Hospice Services
- ☐ Hospital Services
- ☐ Licensed Independent Practitioner's Rehabilitative Services (LIPS)
- ☐ Local Education Agencies (LEA)
- ☐ Medically Complex Children's (MCC) Waivers
- ☐ Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- ☐ Optional State Supplementation (OSS)
- ☐ Pharmacy Services
- ☐ Physicians Laboratories, and Other Medical Professionals
  Specify: _____
- ☐ Private Rehabilitative Therapy and Audiological Services
- ☐ Psychiatric Hospital Services
- ☐ Rehabilitative Behavioral Health Services (RBHS)
- ☐ Rural Health Clinic (RHC)
- ☐ Targeted Case Management (TCM)
- ☐ Other: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature:_____ Date: _____

NCPDP UNIVERSAL CLAIM FORM SAMPLE

TYPE OR PRINT ALL INFORMATION NEATLY AND COMPLETELY IN APPROPRIATE SPACES (PERF)

CARDHOLDER I.D. _____ GROUP I.D. _____

CARDHOLDER NAME (LAST, FIRST, MI) _____ PLAN NAME _____

PATIENT NAME (LAST, FIRST, MI) _____ OTHER COVERAGE CODE (1) _____ PERSON CODE (2) _____

PATIENT DATE OF BIRTH ____ MM ____ DD ____ CCYY PATIENT (3) GENDER CODE _____ PATIENT (4) RELATIONSHIP CODE _____

PHARMACY NAME _____

ADDRESS _____ SERVICE PROVIDER I.D. _____ QUAL (5) _____

CITY _____ PHONE NO. ( ) _____

STATE & ZIP CODE _____ FAX NO. ( ) _____

FOR OFFICE USE ONLY	

WORKERS COMP. INFORMATION
EMPLOYER NAME _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

CARRIER I.D. (6) _____ **EMPLOYER PHONE NO.** _____

DATE OF INJURY ____ MM ____ DD ____ CCYY **CLAIM (7) REFERENCE I.D.** _____

I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.

PATIENT / AUTHORIZED REPRESENTATIVE _____

ATTENTION RECIPIENT PLEASE READ CERTIFICATION STATEMENT ON REVERSE SIDE

1 Sample Form - Not For Distribution

PRESCRIPTION / SERV. REF. #	QUAL. (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL. (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL. (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL. (15)	DIAGNOSIS CODE	QUAL. (16)
A B C					

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL. (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

1

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

2 Sample Form - Not For Distribution

PRESCRIPTION / SERV. REF. #	QUAL. (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL. (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL. (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL. (15)	DIAGNOSIS CODE	QUAL. (16)
A B C					

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL. (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

2

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

NCPDP UNIVERSAL CLAIM FORM (UCF) (PERF)

MAGELLAN MEDICAID ADMINISTRATION

South Carolina Department of Health & Human Services

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*) ☐ Congenital Anomaly ☐ Death (Date: ____/____/____) ☐ Disability ☐ Hospitalization (initial or prolonged) ☐ Life-threatening ☐ Required intervention to prevent permanent impairment/damage ☐ 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? ☐ Yes ☐ No ☐ Doesn't Apply	6. Lot # (if known): _____
7. Exp. Date (if known): _____/_____/_____	8. Event reappeared after reintroduction? ☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No	3. Occupation:	4. Also reported to: ☐ Distributor ☐ Manufacturer ☐ 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/

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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

MAGELLAN MEDICAID ADMINISTRATION

South Carolina Department of Health & Human Services

SOUTH CAROLINA MEDICAID PROGRAM

PRIOR AUTHORIZATION REQUEST – PROTON PUMP INHIBITORS

PRESCRIBER:

NAME: _____
(FIRST) (LAST)

National Provider ID # _____

PHONE # (_____)_____

FAX # (_____)_____

BENEFICIARY:

NAME: _____
(FIRST) (LAST)

MEDICAID #: _____

DATE OF BIRTH: ____/____/____ **SEX:** ☐ M ☐ F

REQUEST DATE: ____/____/____

PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM: _____

PHARMACY: _____ **PHONE:** (_____)_____

Patient's Diagnosis: _____

Have any recent GI procedures been performed? (Check and complete ALL that apply.)

Procedure:	Date of Procedure:	Findings:
☐ Upper GI Series	____/____/____	_____
☐ Barium Swallow	____/____/____	_____
☐ Endoscopy	____/____/____	_____

Has the Patient had a failure (4 week trial) on an acute dose of an H2 Receptor Antagonist in the past 2 years? ☐ Yes ☐ No
If Yes, Medication Name: _____ **Strength:** _____ **Frequency**_____ **Date of trial:** ____/____/____

Is the Patient H.Pylori positive? ☐ Yes ☐ No **Date:** ____/____/____

Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page. _____

_____

_____

_____

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/

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SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

South Carolina Medicaid Program

Prior Authorization Request Form

Human Growth Hormone – Adult Treatment

Request Date: ___ / ___ / _____

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

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

Drug Name:* _____ Strength: _____ Duration: _____

* If request is for a non-preferred agent, please include clinical criteria for this particular agent over one of the following: Genotropin®, Norditropin®, Saizen®

Dosage Schedule: _____

Diagnosis: _____ ICD Code: _____

Initiation of Therapy: ☐ Yes ☐ No Continuation of Therapy: ☐ Yes ☐ No

Provocation Stimulation Test and Findings _____

1. Is patient receiving full supplementation of deficient pituitary hormones? ☐ Yes ☐ No
   1a. If YES, please list: _____
2. Does the patient have reduced bone mineral density (BMD) using the WHO criteria? ☐ Yes ☐ No
   2a. If YES, please provide T-Score: _____
3. Does the patient have a high-risk lipid profile? ☐ Yes ☐ No
   3a. If YES, please provide total cholesterol or LDL level: _____
4. Does the patient have at least 2 pituitary hormone deficiencies other than Growth Hormone? ☐ Yes ☐ No
   4a. If YES, please list: _____
5. For renewal, is the patient showing improvement? ☐ Yes ☐ No
   5a. Increase in BMD per DEXA scan? ☐ Yes ☐ No
   5b. Reduction in lipid panel? ☐ Yes ☐ No
   Document percent reduction: _____

PRESCRIBER'S SIGNATURE: _____ DATE: _____

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℠

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SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

South Carolina Medicaid Program

Prior Authorization Request Form

Human Growth Hormone – Pediatric Treatment

Request Date: ___ / ___ / ____

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

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 (Note: Must be a Nephrologist or Pediatric Endocrinologist)

Prescriber's Phone Number | Prescriber's Fax Number

Prescriber's Office Staff Member Completing This Form

Pharmacy | Phone:

III. DRUG INFORMATION

Drug Name: _____ Strength: _____ Duration: _____

If request is for a non-preferred agent, please include clinical criteria for this particular agent over one of the following: Genotropin®, Norditropin®, Saizen®

Dosage Schedule: _____

Diagnosis: _____ ICD Code: _____

Birth Weight: _____ Gestational Age at Birth: _____

Last Recorded Height: _____ Date of Measurement: _____

Last Recorded Weight: _____ Date of Measurement: _____

Biological Mother's Height: _____ Biological Father's Height: _____

Therapy: ☐ Initiation ☐ Continuation

Bone Age Studies Results: _____

Epiphyses: ☐ Open ☐ Closed

Has patient been evaluated by: ☐ Endocrinologist ☐ Pediatric Nephrologist

Current Growth Velocity: _____

**** PLEASE ATTACH COPIES OF GROWTH CHARTS TO THIS REQUEST. ****

PRESCRIBER'S SIGNATURE: _____ DATE _____

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/

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SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

South Carolina Medicaid Program

Prior Authorization Request Form

Antipsychotics – Children ≤ 6 Years

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

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

Dosage Schedule: _____

Diagnosis: _____ ICD Code: _____

1. Is the Prescriber a Psychiatrist? Or, has the Prescriber consulted with a Psychiatrist before requesting this medication? ☐ Yes ☐ No
2. Has the patient received a developmentally-appropriate, comprehensive psychiatric assessment with diagnoses, impairments, treatment target and treatment plans clearly identified and documented? ☐ Yes ☐ No
3. Has informed consent for this medication been obtained from the parent or guardian? ☐ Yes ☐ No
4. Has a family assessment been performed (including parental psychopathology and treatment needs) and have family functioning and parent-child relationship been evaluated? ☐ Yes ☐ No
5. Psychosocial treatment has been in place for at least 12 weeks without adequate clinical response and psychosocial treatment with parental involvement will continue for the duration of medication therapy. ☐ Yes ☐ No
   Select YES, if this statement is true.
6. Is the requested medication the only antipsychotic medication the patient will be receiving? ☐ Yes ☐ No
   6a. If NO to the question above, is one agent being tapered while titrating another? ☐ Yes ☐ No
7. Is this request for continuation of an established therapy? Or, for continuation of therapy initiated during an in-patient hospitalization? ☐ Yes ☐ No
   7a. If YES to the question above, please document the specific medication: _____
8. **If Tourette's is listed as the diagnosis, please answer the following questions:**
   8a. Has the patient failed treatment with previous therapy (such as clonidine or guanfacine)? ☐ Yes ☐ No
   8b. If YES to the question above, please document the specific medication: _____

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

Fax completed forms to Magellan Rx Management.
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Revised: September 2015

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

Magellan Rx MANAGEMENT

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SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

South Carolina Medicaid Program

Prior Authorization Request Form

Hepatitis B

Request Date: ___ / ___ / ____

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

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

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

Diagnosis: _____ ICD Code: _____

1. Has the patient had an HIV screen? ☐ Yes ☐ No
   1a. If YES, please document results: _____
2. Has the patient had a liver biopsy? ☐ Yes ☐ No
   2a. If YES, please document results: _____
3. Does the patient have compromised renal function? ☐ Yes ☐ No
   3a. If YES, please provide creatinine clearance rate: _____

** Please attach a copy of lab results noted above with this form for our records **

4. Does the patient have autoimmune hepatitis? ☐ Yes ☐ No
5. Is the patient (or patient's partner) pregnant? ☐ Yes ☐ No
6. Is there a history of kidney, lung, or heart transplant? ☐ Yes ☐ No
7. Does the patient have uncontrolled depression? ☐ Yes ☐ No
8. Does the patient have severe HTN, heart failure, or CAD? ☐ Yes ☐ No

South Carolina Medicaid has instituted a program to more closely monitor Hepatitis B patients in an attempt to improve medication compliance. To assist in the program, please provide the patient's phone number(s).

Phone Number #1: _____ Phone #2: _____

PRESCRIBER'S SIGNATURE: _____ DATE _____

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℠

MAGELLAN MEDICAID ADMINISTRATION

South Carolina Department of Health & Human Services

SOUTH CAROLINA MEDICAID PROGRAM

PRIOR AUTHORIZATION REQUEST – HEPATITIS C

PRESCRIBER:

NAME: _____
(FIRST) (LAST)

National Provider ID #_____

PHONE # (_____)_____

FAX # (_____)_____

BENEFICIARY:

NAME: _____
(FIRST) (LAST)

MEDICAID #: _____

DATE OF BIRTH: ____/____/____ **SEX:** ☐ M ☐ F

REQUEST DATE: ____/____/____

PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM: _____

PHARMACY: _____ **PHONE:** (_____)_____

DRUG NAME	DOSE	STRENGTH	LENGTH OF THERAPY

DIAGNOSIS: _____
GENOTYPE: _____
INITIAL VIRAL LOAD: _____ **DATE TAKEN:** ____/____/____

HAS THE PATIENT HAD A LIVER BIOPSY? ☐ Yes ☐ No
If yes, please document results: _____
(***Please attach a copy of lab results noted above with this form for our records***)

1. **Does the patient have autoimmune hepatitis?** ☐ Yes ☐ No
2. **Is the patient (or patient's partner) pregnant?** ☐ Yes ☐ No
3. **Does the patient have a hemoglobinopahty? (e.g., sickle cell, thalassemia)** ☐ Yes ☐ No
4. **Is there a history of kidney, lung or heart transplant?** ☐ Yes ☐ No
5. **Does the patient have untreated hyperthyroidism?** ☐ Yes ☐ No
6. **Does the patient have uncontrolled depression?** ☐ Yes ☐ No
7. **Does the patient have severe HTN, heart failure or CAD?** ☐ Yes ☐ No
8. **Is the patient going to be taking a Ribavirin?** ☐ Yes ☐ No

If not, please explain contraindicaton: _____
_____

South Carolina Medicaid has instituted a program to more closely monitor Hepatitis C patients in an attempt to improve medication compliance. To assist in the program, please provide the patient's phone number(s). _____
_____

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/