BlueChoice® HealthPlan of South Carolina Medicaid

SOUTH CAROLINA Healthy Connections MEDICAID

Specialty Pharmaceutical Authorization Request

Member information		
Member name:		
Member ID number:		
Gender: ☐ Male ☐ Female		
DOB:		
Member address:		
City:	State:	ZIP code:
Primary phone number:		

Prescriber information		
Prescriber name:		
License number:		
NPI:		
Tax ID number:		
Prescriber address:		
City:	State:	ZIP code:

Contact information
Name of person completing this form:
Primary phone number:
Fax number:

Diagnosis and clinical information	
Diagnosis (ICD-10)	
Code:	Description:
Code:	Description:
Code:	Description:
Code:	Description:
Medication	
Need medication by this date:	
Ship medication to: ☐ Member ☐ Office ☐ Other:	
Dosage and regimen prescribed:	
Anticipated duration:	
Nursing	
Is injection training/home health visit necessary? ☐ Yes ☐ No	
If no, indicate the reason: ☐ MD office to administer ☐MD office training member ☐Home health to administer ☐Member (family) already independent	

Medication information				
Medication:	Dose/strength:	Directions:	Quantity:	Special instructions:

Authorization number: _____

THIS MESSAGE IS INTENDED ONLY FOR THE USE OF THE MEDICAL PROVIDER TO WHOM IT IS ADDRESSED AND MAY CONTAIN HEALTH INFORMATION THAT IS PROTECTED BY LAW.

If this transmission contains the protected health information of an individual who is unknown to your practice, please notify us immediately by calling **866-757-8286**. Please be advised that copying, sharing or any further use or disclosure of this communication is strictly prohibited.