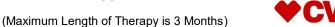
FLORIDA MEDICAID PRIOR AUTHORIZATION



Albumin





Note: Form must be completed in full. An incomplete form may be returned.

| Recipient's Medicaid ID# | | | | | | | | | | Date of Birth (MM/DD/YYYY) | | | | | | | | | | | | | | | | | | | |
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| Prescriber's Signature: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| cop | ies c | of rela | ated | labs | i. | | | | | | | | | | | | | | | | | | | | | | | | |

The provider must retain copies of all documentation for five years.

Call or Fax Information to: Florida Community Care Prior Confi

Authorization

Phone number for non-specialty Prior Authorization: 877-433-7643 Phone number for specialty Prior Authorization: 866-814-5506 Fax number for non-specialty Prior Authorization: 866-255-7569 Fax number for non-specialty Prior Authorization: 866-249-6155 Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via return fax) immediately and arrange for the return or destruction of these documents. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.



FLORIDA MEDICAID PROTOCOL **Albumin**



Approved Indications:

- Hypoalbuminemia due to acute liver failure
- Hepatic Cirrhosis
- Nephrotic Syndrome
- Tuberculosis
- Trauma
- Burns

Do not approve for caloric supplementation or as an additive to TPN.

Approval Period:

Length of Prescription Only