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FLORIDA MEDICAID PRIOR AUTHORIZATION

Albumin

(Maximum Length of Therapy is 3 Months)

FLORIDA COMMUNITY CARE

CVS caremark

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

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) / /

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber's Phone Number - -

Prescriber's Fax Number - -

Pharmacy's Name

Pharmacy's Medicaid Provider #

Pharmacy's Phone Number -

Pharmacy's Fax Number -

1. If the diagnosis is one of the following, please indicate which one (must provide progress notes and medical records indicating the diagnosis).
   - ☐ Hypoalbuminemia due to Acute Liver Failure
   - ☐ Burns
   - ☐ Hepatic Cirrhosis
   - ☐ Nephrotic Syndrome
   - ☐ Trauma
   - ☐ Tuberculosis
2. Will Albumin be used in TPN solutions?
   ○ Yes ○ No ***(If Yes, PA Denied)***
3. Dosage and frequency of dosing: _____

Prescriber's Signature: _____ **Date:** _____

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), and the most recent copies of related labs.

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

Call or Fax Information to: Florida Community Care Prior 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

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