Reset Form | Print Form

FLORIDA MEDICAID PRIOR AUTHORIZATION

Panretin®

Maximum length of approval = one year
Note: Form must be completed in full.
An incomplete form may be returned.

FLORIDA COMMUNITY CARE

CVS caremark

Recipient's Medicaid ID#

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

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number - -

Prescriber Fax Number - -

Pharmacy Name

Pharmacy Medicaid Provider #

Pharmacy Phone Number - -

Pharmacy Fax Number - -

1. Does the recipient have AIDS related Kaposi's Sarcoma (KS)?

   ☐ Yes ☐ No

2. Is the recipient currently on any systemic anti-KS treatment?

   ☐ Yes ☐ No

3. How many new KS lesions does the recipient have since last month?

   _____

4. What size are the lesions in cm?

   _____

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:

- Topical treatment of AIDS related Kaposi Sarcoma (KS) Lesions

Treatment Guidelines:

- Total number of lesions must be less than ten
- Lesions size must be between two or three centimeters
- Cannot be on systemic KS treatment