



FLORIDA MEDICAID PRIOR AUTHORIZATION

Albumin

(Maximum Length of Therapy is 3 Months)



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

- 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
- Will Albumin be used in TPN solutions?
 Yes No *(If Yes, PA Denied)*
- 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 specialty Prior Authorization: 866-249-6155

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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