Print Form Reset Form

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 License # (ME, OS, ARNP, PA)

Prescriber Phone Number -

Prescriber Fax Number -

Pharmacy Name

Pharmacy Medicaid Provider #

Pharmacy Phone Number -

Pharmacy 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), a copy of the original prescription, and the most recent copies of related labs.

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

Fax Information to:

PERFORMRx℠

Pharmacy Provider Services
Fax: 855-825-2717
Phone: 1-800-617-5727

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