Reset Form Print Form

United Healthcare Community Plan

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 - -

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: All copies of medical records (e.g., 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.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center:
1-800-310-6826

02.01.2025

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