



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#

Grid for Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth

Recipient's Full Name

Grid for Recipient's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber's NPI

Grid for Prescriber's NPI

Prescriber's Phone Number

Grid for Prescriber's Phone Number

Prescriber's Fax Number

Grid for Prescriber's Fax Number

Pharmacy's Name

Grid for Pharmacy's Name

Pharmacy's Medicaid Provider #

Grid for Pharmacy's Medicaid Provider #

Pharmacy's Phone Number

Grid for Pharmacy's Phone Number

Pharmacy's Fax Number

Grid for Pharmacy's Fax Number

- 1. If the diagnosis is one of the following, please indicate which one...
 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

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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