Reset Form Print Form

United Healthcare Community Plan

FLORIDA MEDICAID PRIOR AUTHORIZATION

Panretin®

Maximum length of approval = one year
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 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

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

   What size are the lesions in cm? _____

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:

- 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