Reset Form Print Form

MEDICATION PRIOR AUTHORIZATION REQUEST FORM
FAX this completed form to 1-833-546-1507
OR Mail request to: Pharmacy Services Prior Authorization Dept.
5 River Park Place East, Suite 210 | Fresno, CA 93720
Call 1-866-399-0928 to request a 72-hour supply of medication.
Pharmacy Services will respond via fax or phone within 24 hours of receipt of all necessary information,
except during weekends and holidays. For immediate response on weekends and holidays, NurseWise will answer your call.

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.

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Albumin

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