

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.

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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.												ıτ																	

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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