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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 License # (ME, OS, ARNP, PA)

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

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

   _____

4. What size are the lesions in cm?

   _____

Prescriber's Signature: _____ **Date:** _____

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs.

The provider must retain copies of all documentation for five years.

Fax Information to:

PERFORMRx℠

Pharmacy Provider Services
Fax: 855-825-2717
Phone: 1-800-617-5727

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