



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#

Grid for Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth (MM/DD/YYYY)

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 Phone Number

Grid for Prescriber Phone Number

Prescriber Fax Number

Grid for Prescriber Fax Number

Pharmacy Name

Grid for Pharmacy Name

Pharmacy Medicaid Provider #

Grid for Pharmacy Medicaid Provider #

Pharmacy Phone Number

Grid for Pharmacy Phone Number

Pharmacy Fax Number

Grid for 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: 1-855-258-1593

02.15.2024

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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