



MEDICATION PRIOR AUTHORIZATION REQUEST FORM
FAX this completed form to 1-888-865-6531
OR Mail request to: Pharmacy Services Prior Authorization Dept.
5 River Park Place East, Suite 210 | Fresno, CA 93720

Reset Form

Print Form

Call 1-833-705-1351 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,
expect during weekends and holidays. For immediate response on weekends and holidays, NurseWise will answer your call.

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.

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited.



MEDICATION PRIOR AUTHORIZATION REQUEST FORM

FAX this completed form to 1-888-865-6531

**OR Mail request to: Pharmacy Services Prior Authorization Dept.
5 River Park Place East, Suite 210 | Fresno, CA 93720**

Call 1-833-705-1351 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, expect during weekends and holidays. For immediate response on weekends and holidays, NurseWise will answer your call.

Panretin®

Maximum length of approval = one year

Note: Form must be completed in full. An incomplete form may be returned.

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