ENCY 20	A MEDICAID PRIOR AU Panretin <sup>®</sup> Maximum length of approval = o Note: Form must be completed An incomplete form may be ret	one year I in full.
Recipient's Medicaid ID#	Date of Birth (MM/DD/YYYY	Y)
Recipient's Full Name		
Prescriber's Full Name		
Prescriber's NPI		
Prescriber Phone Number		Prescriber Fax Number
Pharmacy Name		
Pharmacy Medicaid Provider #		
Pharmacy Phone Number		Pharmacy Fax Number
1. Does the recipient have AIDS relat	ed Kaposi's Sarcoma (KS)?	
Yes No		
2. Is the recipient currently on any system	stemic anti-KS treatment?	
Yes No		
How many new KS lesions does th	e recipient have since last month?	
What size are the lesions in cm? _		
		Defe
Prescriber's Signature:		Date: tions and recent chart notes). and the most recent

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

Mail or Fax Information to: Prime Therapeutics State Government Solutions LLC Prior Authorization P. O. Box 7082 Tallahassee, FL 32314-7082 Phone: 877-553-7481 Fax: 877-614-1078 **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. If you have received this information in error, please notify the sender (via return fax) immediately and arrange for the return or destruction of these documents. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.



## FLORIDA MEDICAID PROTOCOL Panretin<sup>®</sup> Gel (Alitretinoin)

## **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