



# New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9)

DATE OF MEDICATION REQUEST:     /     /

## SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEDICAID ID NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

DATE OF BIRTH:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

GENDER:  Male  Female

Drug Name

Strength

Dosing Directions

Length of Therapy

## SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

SPECIALTY:

NPI NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

PHONE NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

FAX NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

## SECTION III: CLINICAL HISTORY

1. Please list the diagnosis for which this medication is being requested for and confirmation test if applicable:

2. Is the patient's age 18 years of age or older?

Yes  No

3. Is the prescriber a cardiologist, lipidologist or endocrinologist or one of these specialist has been consulted?

Yes  No

4. Has the patient tried and failed maximum tolerated doses of atorvastatin or rosuvastatin and one other cholesterol medication?

Yes  No

5. If YES, please list medication, dose not tolerated and length of treatment.

Will the maximally tolerated statin continue if requesting Repatha™?

Yes  No

6. Please list lipid panel results:

Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.

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For renewal after initial 6 months request, Please list recent lipid panel results:

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I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_