



**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:

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FIRST NAME:

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

MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER: Male Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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SECTION III: CLINICAL HISTORY

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

- Is the patient 18 years of age or older (Praluent®) or 10 years of age or older (Repatha™)? Yes No
- Is the prescriber a cardiologist, lipidologist, or endocrinologist, or has one of these specialists been consulted? Yes No
- Has the patient tried and failed maximum tolerated doses of atorvastatin or rosuvastatin and one other cholesterol medication? Yes No
 - If **yes**, please list medication, dose not tolerated, and length of treatment.

(Form continued on the next page.)



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Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9)

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

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PATIENT FIRST NAME:

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SECTION III: CLINICAL HISTORY (CONTINUED)

6. Please list lipid panel results:

7. For renewal after initial 6-month request, please list recent lipid panel results:

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

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: _____