



New Hampshire Medicaid Fee-for-Service (FFS) Program

Prior Authorization

Adenosine triphosphate-citrate lyase inhibitor Medication

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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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:

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

PHONE NUMBER:

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

FAX NUMBER:

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SECTION III: CLINICAL HISTORY

1. Does the patient have heterozygous familial hypercholesterolemia (HeFH)? ☐ Yes ☐ No
2. Does the patient have established atherosclerotic cardiovascular disease (ASCVD)? ☐ Yes ☐ No
3. Is the patient receiving maximally-tolerated statin? ☐ Yes ☐ No
If yes, list medication: _____
If no, is the patient unable to tolerate any dose of statin? ☐ Yes ☐ No
4. Will the patient continue to receive the statin? ☐ Yes ☐ No
5. Has the patient achieved the target LDL-C with the current regimen? ☐ Yes ☐ No

(Form continued on the next page.)



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PATIENT LAST NAME:

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PATIENT FIRST NAME:

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SECTION III: CLINICAL HISTORY (*Continued*)

6. In which high-risk group would the patient be considered?:

- ☐ Extremely high risk with an LDL-C \geq 70 mg/dL
- ☐ Very high risk with an LDL-C \geq 100 mg/dL
- ☐ High risk with an LDL-C \geq 130 mg/dL

7. Please list lipid panel results: _____

8. *Nexlizet™ only*: Does the patient have an allergy or hypersensitivity to ezetimibe?

☐ Yes ☐ No

9. *Nexlizet™ only*: Is the patient currently receiving gemfibrozil?

☐ Yes ☐ No

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: _____