



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

Prior Authorization Drug Approval Form

Familial Chylomicronemia Syndrome

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

Grid for last name input

FIRST NAME:

Grid for first name input

MEDICAID ID NUMBER:

Grid for Medicaid ID number input

DATE OF BIRTH:

Grid for date of birth input

GENDER: Male Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

Grid for last name input

FIRST NAME:

Grid for first name input

SPECIALTY:

NPI NUMBER:

Grid for NPI number input

PHONE NUMBER:

Grid for phone number input

FAX NUMBER:

Grid for fax number input

SECTION III: CLINICAL HISTORY

- 1. Is the patient 18 years of age and older?
2. Does the patient have a diagnosis of familial chylomicronemia syndrome?
3. Does the patient have hypersensitivity to any component or any excipients of the product?





New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization Drug Approval Form
 Familial Chylomicronemia Syndrome

PATIENT LAST NAME:

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

PATIENT FIRST NAME:

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

4. Is the prescriber a cardiologist, endocrinologist, geneticist, or lipidologist, or has the prescriber consulted with a specialist in familial chylomicronemia syndrome? Yes No
5. Is there any additional information that would help in the decision-making process?
 If additional space is needed, please use a separate sheet.

SECTION IV: RENEWAL

1. Has the patient had clinical benefit with the use of Tryngolza™ or Redemplo®? Yes No
2. Has the patient experienced any treatment-restricting adverse effects? 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:** _____