





# New Hampshire Medicaid Fee-for-Service Program

## Prior Authorization Drug Approval Form

## Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9)

**DATE OF MEDICATION REQUEST:** / /

**PATIENT LAST NAME:**

**PATIENT FIRST NAME:**

### **SECTION III: CLINICAL HISTORY (CONTINUED)**

3. Is the patient currently receiving a maximally tolerated statin?  Yes  No  
If no, is the patient unable to tolerate statins?  Yes  No

4. Please list lipid panel results:

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

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6. 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:** \_\_\_\_\_

**Phone:** 1-866-675-7755

**Fax:** 1-888-603-7696