Reset Form Print Form

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:

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. Has the patient tried and failed maximum tolerated doses of atorvastatin or rosuvastatin and one other cholesterol medication? ☐ Yes ☐ No
   a. Please list any other medications tried, dose not tolerated, and length of treatment.

(Form continued on the next page.)

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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:

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

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**: _____

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