



New Hampshire AIDS Drug Assistance 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:

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MEDICAID ID NUMBER:

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

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. 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 ☐ Yes ☐ No other cholesterol medication?
 - a. Please list any other medications tried, dose not tolerated, and length of treatment.

(Form continued on the next page.)



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Prior Authorization Drug Approval Form**

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)

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:** _____

Phone: 1-800-424-7901

Fax: 1-800-424-7984

