



**New Hampshire AIDS Drug Assistance Program  
Prior Authorization Drug Approval Form**

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:

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

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:

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PHONE NUMBER:

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FAX NUMBER:

				-					-				
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**SECTION III: CLINICAL HISTORY**

- Does the patient have heterozygous familial hypercholesterolemia (HeFH)?     Yes     No
- Does the patient have established atherosclerotic cardiovascular disease (ASCVD)?     Yes     No
- Is the patient receiving maximally-tolerated statin?     Yes     No  
If yes, list medication: \_\_\_\_\_
- Will the patient continue to receive the statin?     Yes     No
- Has the patient achieved the target LDL-C with the current regimen?     Yes     No

*(Form continued on the next page.)*



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Adenosine triphosphate-citrate lyase inhibitor Medication

DATE OF MEDICATION REQUEST:    /    /

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. Is the patient a smoker?

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:** \_\_\_\_\_