



**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:

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

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**

- Please list the diagnosis for which this medication is being requested for and confirmation test if applicable:  
\_\_\_\_\_
- Is the patient 18 years of age or older (Praluent®) or 13 years of age or older (Repatha™)?     Yes     No
- Is the prescriber a cardiologist, lipidologist, or endocrinologist, or has one of these specialists been consulted?     Yes     No
- Has the patient tried and failed maximum tolerated doses of atorvastatin or rosuvastatin and one other cholesterol medication?     Yes     No
  - If **yes**, please list medication, dose not tolerated, and length of treatment.

(Form continued on the next page.)



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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)**

6. Please list lipid panel results:

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

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8. Is there any additional information that would help in the decision-making process? **If additional space is needed, please use another page.**

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