



# New Hampshire Medicaid Fee-for-Service (FFS) Program

## Prior Authorization

Adenosine triphosphate-citrate lyase inhibitor Medication

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

(Form continued on the next page.)



## New Hampshire Medicaid Fee-for-Service (FFS) Program

### Prior Authorization

Adenosine triphosphate-citrate lyase inhibitor Medication

DATE OF MEDICATION REQUEST:     /     /

PATIENT LAST NAME:

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

PATIENT FIRST NAME:

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

#### 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. *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: \_\_\_\_\_