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# 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.)*

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**Prior Authorization**
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**DATE OF MEDICATION REQUEST: / /**

**PATIENT LAST NAME:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |

**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 ≥ 70 mg/dL
   - ☐ Very high risk with an LDL-C ≥ 100 mg/dL
   - ☐ High risk with an LDL-C ≥ 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**: _____