Reset Form | Print Form

New Hampshire AIDS Drug Assistance 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 AIDS Drug Assistance 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 ≥ 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. *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**: _____