AmeriHealth Caritas™
New Hampshire

Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9)

Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / _____

Patient information and medication requested	
Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information			
Prescriber last name:		Prescriber first name:	
Prescriber address:		Prescriber representative:	
Specialty:		NPI number:	
Phone #:	Fax #:		

Clinical history
1. Please list the diagnosis for which this medication is being requested for and confirmation test if applicable:
2. Is the patient 18 years of age or older? ☐ Yes ☐ No
3. Is the prescriber a cardiologist, lipidologist, or endocrinologist, or has one of these specialists been consulted? ☐ Yes ☐ No
4. Has the patient tried and failed maximum tolerated doses of atorvastatin or rosuvastatin and one other cholesterol medication? ☐ Yes ☐ No If yes, please list the medication, dose not tolerated, and the length of the treatment.
5. Will the maximally tolerated statin continue if requesting Repatha™? ☐ Yes ☐ No
6. Please list lipid panel results:
7. Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.
8. For renewal after initial 6 months request, please list recent lipid panel results:

Signature of prescriber:_____ Date: _____
(prescriber signature mandatory)

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.