PRIOR AUTHORIZATION REQUEST

Rezdiffra

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the request an INITIAL or CONTINUATION of therapy? [] Initial (If checked, go to 13) [] Continuation (If checked, go to 2)		
2	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 13.]	Yes	No

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3	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 13.]	Yes	No
4	Has the patient been established on therapy for at least 3 months? [If no, skip to question 13.]	Yes	No
5	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
6	Has documentation been submitted to confirm the patient has had worsening of fibrosis? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 8.]	Yes	No
7	Has documentation been submitted to confirm that the patient has had no worsening of MASH/NASH and improvement in fibrosis by at least 1 stage? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
8	Has documentation been submitted to confirm the patient does not have cirrhosis (fibrosis stage F4)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
9	Does the provider attest that the patient meets ONE of the following: A) A female patient with less than or equal to 20 grams/day alcohol consumption, B) A male patient with less than or equal to 30 grams/day alcohol consumption? [If no, no further questions.]	Yes	No
10	Does the provider attest that the patient has been counseled on lifestyle modifications (diet and exercise)? [If no, no further questions.]	Yes	No
11	Is the requested medication prescribed by or in consultation with a hepatologist, endocrinologist, or gastroenterologist? [If no, no further questions.]	Yes	No
12	Will the requested medication be prescribed in combination with any strong CYP2C8 inhibitors or organic anion-transporting polypeptides (OATP1B1, OATP1B3) inhibitors? [No further questions.]	Yes	No
13	What is the indication or diagnosis? [] Metabolic dysfunction-associated steatohepatitis/non-alcoholic steatohepatitis (MASH/NASH) (If checked, go to 14) [] Other (If checked, no further questions)		

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14	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
15	Does the patient have a pre-treatment fibrosis score of F2 or F3? [If no, no further questions.]	Yes	No
16	Has documentation been submitted confirming MASH/NASH via one of the following methods? ACTION REQUIRED: Submit supporting documentation. [] Liver biopsy within 6 months of prior authorization request (If checked, go to 17) [] Imaging exams within 3 months of prior authorization request (If checked, go to 18) [] None of the above (If checked, no further questions)		
17	Does the liver biopsy show the patient has a non-alcoholic fatty liver disease activity score of at least 4 with a score of greater than 1 in ALL of the following: A) Steatosis, B) Ballooning, C) Lobular inflammation? [If yes, skip to question 19.] [If no, no further questions.]	Yes	No
18	Do imaging exams (elastography, computed tomography, magnetic resonance imaging) confirm the patient has a fibrosis score of F2 or F3? [If no, no further questions.]	Yes	No
19	Has documentation been submitted that confirms the patient has THREE or more of the following metabolic risks: A) Central obesity, B) Reduced high-density lipoprotein cholesterol, C) Hypertension, D) Hypertriglyceridemia, E) Pre-diabetes? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
20	Does the provider attest that the patient meets ONE of the following: A) A female patient with less than or equal to 20 grams/day alcohol consumption, B) A male patient with less than or equal to 30 grams/day alcohol consumption? [If no, no further questions.]	Yes	No
21	Does the provider attest that the patient has been counseled on lifestyle modifications (diet and exercise)? [If no, no further questions.]	Yes	No
22	Is the requested medication prescribed by or in consultation with a hepatologist, endocrinologist, or gastroenterologist? [If no, no further questions.]	Yes	No
23	Will the requested medication be prescribed in combination with any strong CYP2C8 inhibitors or organic anion-transporting polypeptides (OATP1B1, OATP1B3) inhibitors?	Yes	No

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Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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