



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? | |
| | <input type="checkbox"/> Initial (If checked, go to 13) | |
| | <input type="checkbox"/> 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 | <p>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.]</p> | Yes | No |
| 4 | <p>Has the patient been established on therapy for at least 3 months? [If no, skip to question 13.]</p> | Yes | No |
| 5 | <p>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.]</p> | Yes | No |
| 6 | <p>Has documentation been submitted to confirm the patient has had worsening of fibrosis? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 8.]</p> | Yes | No |
| 7 | <p>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.]</p> | Yes | No |
| 8 | <p>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.]</p> | Yes | No |
| 9 | <p>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.]</p> | Yes | No |
| 10 | <p>Does the provider attest that the patient has been counseled on lifestyle modifications (diet and exercise)? [If no, no further questions.]</p> | Yes | No |
| 11 | <p>Is the requested medication prescribed by or in consultation with a hepatologist, endocrinologist, or gastroenterologist? [If no, no further questions.]</p> | Yes | No |
| 12 | <p>Will the requested medication be prescribed in combination with any strong CYP2C8 inhibitors or organic anion-transporting polypeptides (OATP1B1, OATP1B3) inhibitors? [No further questions.]</p> | Yes | No |
| 13 | <p>What is the indication or diagnosis?</p> <p><input type="checkbox"/> Metabolic dysfunction-associated steatohepatitis/non-alcoholic steatohepatitis (MASH/NASH) (If checked, go to 14)</p> <p><input type="checkbox"/> Other (If checked, no further questions)</p> | | |

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| 14 | Is the patient 18 years of age or older? [If no, no further questions.] | Yes | No |
| 15 | What is the patient's pre-treatment fibrosis score? <input type="checkbox"/> F0, F1, F1-F2 (If checked, no further questions) <input type="checkbox"/> F2, F2-F3, F3 (If checked, go to 16) <input type="checkbox"/> F3-F4, F4 (If checked, no further questions) | | |
| 16 | Has documentation been submitted confirming MASH/NASH via one of the following methods? ACTION REQUIRED: Submit supporting documentation. <input type="checkbox"/> Liver biopsy within 6 months of prior authorization request (If checked, go to 17) <input type="checkbox"/> Imaging exams within 3 months of prior authorization request (If checked, go to 18) <input type="checkbox"/> 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 | Has the patient tried and failed Wegovy at the recommended dosage of 2.4 mg once weekly for at least 3 months OR at a dosage of 1.7 mg once weekly for at least 3 months? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 24.] | Yes | No |
| 23 | Has documentation been submitted to confirm that the patient has an intolerance or contraindication to Wegovy? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.] | Yes | No |

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| 24 | Is the requested medication prescribed by or in consultation with a hepatologist, endocrinologist, or gastroenterologist? [If no, no further questions.] | Yes | No |
| 25 | Will the requested medication be prescribed in combination with any strong CYP2C8 inhibitors or organic anion-transporting polypeptides (OATP1B1, OATP1B3) inhibitors? | Yes | No |

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.

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