Jefferson Health Plans

# *PRIOR AUTHORIZATION REQUEST FORM*

Individual and Family Plans

## Rezdiffra

**Fax back to: (833) 605-4407**

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

| **Patient Name:** | **Prescriber Name:** |
|---|---|
| Member Number: | Fax: Phone: |
| Date of Birth: | Office Contact: |
| Line of Business: □ Exchange - PA | NPI: State Lic ID: |
| Address: | Address: |
| City, State ZIP: | City, State ZIP: |
| Primary Phone: | **Specialty/facility name (if applicable):** |

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

| | |
|---|---|
| Drug Name: | |
| Strength: | |
| Directions / SIG: | |

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

**Please answer the following questions and sign.**

Q1. Is this a request for renewal? If YES, go to question 2. If NO, go to question 4.

☐ Yes ☐ No

Q2. Is the patient prescribed a dose and duration of therapy consistent with the FDA approved package labeling?

☐ Yes ☐ No

Q3. Is there documentation of positive clinical response and tolerability to requested medication?

☐ Yes ☐ No

Q4. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q5. Is the medication prescribed by or in consultation with a hepatologist or gastroenterologist?

☐ Yes ☐ No

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Q6. Does the patient have any of the following?

- Stage F4 liver fibrosis (cirrhosis)
- Significant alcohol consumption (= 2 alcoholic drinks per day) for a duration of more than 3 months in the last year
- Diagnosis of hepatocellular carcinoma (HCC)
- Chronic liver diseases (e.g., primary biliary cholangitis, primary sclerosing cholangitis, Hepatitis B positive, Active Hepatitis C, etc.)

☐ Yes ☐ No

Q7. Is there a diagnosis of noncirrhotic nonalcoholic steatohepatitis (NASH) confirmed by liver biopsy or imaging confirming steatosis with results attached? (Imaging studies can include ultrasound, Fibroscan CAP, or MRI-PDFF).

☐ Yes ☐ No

Q8. Does the patient have moderate to advanced liver fibrosis (stages F2 or F3) confirmed by liver biopsy performed within the last 6 months? If YES, go to 10. If NO, go to 9.

☐ Yes ☐ No

Q9. Does the patient have moderate to advanced liver fibrosis (stages F2 or F3) confirmed ONE of the following non-invasive tests performed within the last 6 months:

- One of the following Transient elastography (e.g., Fibroscan)
- Shear wave elastography (SWE)
- Magnetic resonance elastography (MRE)

☐ Yes ☐ No

Q10. Is the patient prescribed a dose and duration of therapy consistent with the FDA approved package labeling?

☐ Yes ☐ No

Q11. Is there documentation of counseling the patient on dietary and lifestyle modifications?

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|---|---|

| | |
|---|---|
| ☐ Yes | ☐ No |
| Q12. Additional Information: | |

Prescriber Signature _____ Date _____

*v2025*