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 - Go to 2 ☐ No - Go to 8

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

☐ Yes ☐ No

Q3. Will the patient follow a reduced-calorie diet and increased physical activity plan?

☐ Yes ☐ No

Q4. For a diagnosis of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH), does the patient have any of the following:

☐ Hepatic decompensation or a Model for End-Stage Liver Disease (MELD) score of more than 12 points at screening

☐ Significant alcohol consumption (> 20 grams of alcohol per day for women and > 30 grams for men)

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Patient Name:	**Prescriber Name:**

☐ An aspartate aminotransferase (AST) or alanine aminotransferase (ALT) level of more than 5 times the upper limit of the normal range at screening

☐ An estimated glomerular filtration rate (eGFR) of less than 30ml/min/1.73 m2

☐ Presence or history of hepatocellular carcinoma (HCC)

☐ History of acute pancreatitis

☐ Chronic liver diseases other than metabolic dysfunction–associated steatotic liver disease (MASLD) (e.g., primary biliary cholangitis, primary sclerosing cholangitis, Hepatitis B positive, Active Hepatitis C, etc.)

Q5. For noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH), has the patient had positive clinical effects as evidenced by any of the following:

☐ Optimal control of comorbid metabolic conditions with pertinent labs attached

☐ Weight loss (including recent BMI and weight)

☐ No worsening of MASH as evidenced by improvement in liver enzyme levels and/or non-invasive fibrosis markers if available

Q6. Does the patient continue to take optimized pharmacotherapy for established hypertension, dyslipidemia, or diabetes, if applicable?

☐ Yes ☐ No

Q7. Is there documentation of positive clinical response and tolerability to requested medication?

☐ Yes ☐ No

Q8. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q9. Is the medication prescribed by or in consultation with a hepatologist or gastroenterologist?

☐ Yes ☐ No

Q10. Does the patient have any of the following:

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Patient Name:	**Prescriber Name:**

☐ 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.)

Q11. 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

Q12. For a diagnosis of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH), does the patient have any of the following:

☐ Hepatic decompensation or a Model for End-Stage Liver Disease (MELD) score of more than 12 points at screening

☐ Significant alcohol consumption (> 20 grams of alcohol per day for women and > 30 grams for men)

☐ An aspartate aminotransferase (AST) or alanine aminotransferase (ALT) level of more than 5 times the upper limit of the normal range at screening

☐ An estimated glomerular filtration rate (eGFR) of less than 30ml/min/1.73 m2

☐ Presence or history of hepatocellular carcinoma (HCC)

☐ History of acute pancreatitis

☐ Chronic liver diseases other than metabolic dysfunction–associated steatotic liver disease (MASLD) (e.g., primary biliary cholangitis, primary sclerosing cholangitis, Hepatitis B positive, Active Hepatitis C, etc.)

Q13. Does the patient have moderate to advanced liver fibrosis (stages F2 or F3) confirmed by liver biopsy performed within the last 6 months?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q14. Does the patient have moderate to advanced liver fibrosis (stages F2 or F3) confirmed in ONE of the following non-invasive tests performed within the last 6 months: (select all that apply)

- ☐ Transient elastography (e.g., Fibroscan)
- ☐ Shear wave elastography (SWE)
- ☐ Magnetic resonance elastography (MRE)

Q15. Is the patient prescribed a dose and duration of therapy consistent with the FDA approved package labeling?

☐ Yes ☐ No

Q16. Is there documentation of counseling the patient on dietary and lifestyle modifications?

☐ Yes ☐ No

Q17. Will the patient follow a reduced-calorie diet and increased physical activity plan?

☐ Yes ☐ No

Q18. Additional Information:

Prescriber Signature _____ Date _____

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