



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.

Form with fields: Patient Name, Prescriber Name, Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Phone, Office Contact, NPI, State Lic ID, 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.

Form with fields: 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 8.

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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- 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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<input type="checkbox"/> Stage F4 liver fibrosis (cirrhosis) <input type="checkbox"/> Significant alcohol consumption (= 2 alcoholic drinks per day) for a duration of more than 3 months in the last year <input type="checkbox"/> Diagnosis of hepatocellular carcinoma (HCC) <input type="checkbox"/> Chronic liver diseases (e.g., primary biliary cholangitis, primary sclerosing cholangitis, Hepatitis B positive, Active Hepatitis C, etc.)
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<p>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).</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p>Q12. For a diagnosis of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH), does the patient have any of the following:</p> <input type="checkbox"/> Hepatic decompensation or a Model for End-Stage Liver Disease (MELD) score of more than 12 points at screening <input type="checkbox"/> Significant alcohol consumption (> 20 grams of alcohol per day for women and > 30 grams for men) <input type="checkbox"/> An aspartate aminotransferase (AST) or alanine aminotransferase (ALT) level of more than 5 times the upper limit of the normal range at screening <input type="checkbox"/> An estimated glomerular filtration rate (eGFR) of less than 30ml/min/1.73 m2 <input type="checkbox"/> Presence or history of hepatocellular carcinoma (HCC) <input type="checkbox"/> History of acute pancreatitis <input type="checkbox"/> 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.)

<p>Q13. Does the patient have moderate to advanced liver fibrosis (stages F2 or F3) confirmed by liver biopsy performed within the last 6 months?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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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) <input type="checkbox"/> Transient elastography (e.g., Fibroscan) <input type="checkbox"/> Shear wave elastography (SWE) <input type="checkbox"/> Magnetic resonance elastography (MRE)	
Q15. Is the patient prescribed a dose and duration of therapy consistent with the FDA approved package labeling? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q16. Is there documentation of counseling the patient on dietary and lifestyle modifications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q17. Will the patient follow a reduced-calorie diet and increased physical activity plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q18. Additional Information:	

Prescriber Signature

Date

v2026