HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Rezdiffra - Non-PDL

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

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

Q6. Does the patient have any of the following?

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Member 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.)

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?

☐ Yes ☐ No

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

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

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?

☐ Yes ☐ No

Q12. Additional Information:

☐ Yes ☐ No

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Member Name:	Prescriber Name:

Prescriber Signature

Date

v2025