Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Rezdiffra - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	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 applying the 72 hour 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 the medication being prescribed by or in consultation with a hepatologist or gastroenterologist?

☐ Yes ☐ No

Q2. Is there confirmation that the medication will be used in combination with diet and exercise?

☐ Yes ☐ No

Q3. Is there confirmation that the patient will abstain from alcohol consumption?

☐ Yes ☐ No

Q4. Does the patient have evidence of cirrhosis, hepatic decompensation, or hepatocellular carcinoma?

☐ Yes ☐ No

Q5. Is the request for reauthorization of Rezdiffra? If YES, go to 6. If NO, go to 7.

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

Q6. Is there confirmation of a positive clinical response or stabilization?

☐ Yes ☐ No

Q7. Is there documentation of a diagnosis of metabolic dysfunction-associated steatohepatitis (MASH)/noncirrhotic nonalcoholic steatohepatitis (NASH) confirmed by liver biopsy or imaging (such as ultrasound, Fibroscan CAP, or MRI-PDFF) confirming steatosis with results attached?

☐ Yes ☐ No

Q8. Is there documentation of moderate to advanced liver fibrosis (stage F2 or F3) confirmed by one of the following tests performed within the last 6 months: liver biopsy or non-invasive tests (such as transient elastography (Fibroscan), shear wave elastography, or magnetic resonance elastography)?

☐ Yes ☐ No

Q9. Requested Duration:

☐ 12 Months ☐ Other:

Q10. Additional Information:

_____ _____

Prescriber Signature Date

v2026