



**PRIOR AUTHORIZATION REQUEST FORM**  
Individual and Family Plans

**Rezdifra**

**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.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: <input type="checkbox"/> Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	<b>Specialty/facility name (if applicable):</b>

**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.**

<p><b>Q1. Is this a request for renewal?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Q2. Is the patient prescribed a dose and duration of therapy consistent with the FDA approved package labeling?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Q3. Is there documentation of positive clinical response and tolerability to requested medication?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Q4. Is the patient 18 years of age or older?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Q5. Is the medication prescribed by or in consultation with a hepatologist or gastroenterologist?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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<b>Patient Name:</b>	<b>Prescriber Name:</b>
<p>Q6. Is there a confirmed diagnosis of noncirrhotic nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) by ALL the following:</p> <ul style="list-style-type: none"><li>a. Liver biopsy or imaging (ultrasound, Fibroscan CAP, MRI-PDFF) confirming steatosis with documentation provided.</li><li>b. Moderate to advanced liver fibrosis (stages F2 or F3 fibrosis) confirmed by ONE of the following performed within the last 6 months.<ul style="list-style-type: none"><li>i. Liver biopsy confirming fibrosis F2 or F3</li><li>ii. FIB-4 <math>\geq 1.3</math> AND one of the following non-invasive tests are consistent with F2 or F3 fibrosis.<ul style="list-style-type: none"><li>a. Transient elastography y (e.g., Fibroscan)</li><li>b. Shear wave elastography (SWE)</li><li>c. Magnetic resonance elastography (MRE)</li></ul></li></ul></li></ul> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q7. Is the patient prescribed a dose and duration of therapy consistent with the FDA approved package labeling?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q8. Is there evidence of cirrhosis (stage F4 fibrosis) by imaging or liver biopsy or one or more liver related complications associated with cirrhosis (ex: variceal bleeding, ascites hepatic encephalopathy)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q9. Is there documentation of significant alcohol use (defined as alcohol consumption of more than 1 drink/day for females or more than 2 drinks/day for males)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q10. Is there documentation of counseling the patient on dietary and lifestyle modifications?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q11. Additional Information:</p>	



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<b>Patient Name:</b>	<b>Prescriber Name:</b>
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Prescriber Signature

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Date

v2025