

AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

DUR MEDICATION REZDIFFRA™ (resmetirom)

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name:

Member's First Name:

DIAGNOSIS AND MEDICAL INFORMATION

For initial approval, complete the following questions to receive a 1-year approval:

1. Is the prescriber a specialist in the area of the member's diagnosis (e.g., hepatologist, gastroenterologist, endocrinologist) or has the prescriber consulted with a specialist in the area of the member's diagnosis?
 Yes No
 2. Is the member 18 years of age or older?
 Yes No
 3. Does the member have a diagnosis of metabolic dysfunction-associated steatohepatitis (MASH) with moderate to advanced liver fibrosis (medical records required) AND ALL of the following:
 - The member has stage F2 or F3 fibrosis; **AND**
 - The member has ONE of the following:
 - A liver biopsy showing fibrosis stage 2 or 3; **OR**
 - ***Please attach documentation of the liver biopsy that was done with the results.***
 - A non-invasive liver test showing fibrosis stage 2 or 3?
 - ***Please attach documentation of the non-invasive liver test that was done with the results.***
- Yes No

(Form continued on next page.)

Member's Last Name:

Member's First Name:

4. Does the prescriber attest that the member has received lifestyle counseling on nutrition and exercise?

Yes No

5. Does the member have any of the following:

- Decompensated cirrhosis
- Moderate to severe hepatic impairment (Child-Pugh class B or C)
- History of significant alcohol consumption (> 20 g/day for women and > 30 g/day for men) for a period of more than 3 consecutive months within 1 year prior to screening?

Yes No

For renewal, complete the following questions to receive a 1-year approval:

6. Does the member continue to meet the above criteria (questions 1 through 5)?

Yes No

7. Does the member continue to experience clinical benefit from the requested treatment?

Yes No

Prescriber Signature (Required)

Date

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.

Submission of documentation does NOT guarantee coverage.