SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Rezdiffra™ (resmetirom)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended Dosing: <100 kg: 80 mg once daily. ≥100 kg: 100 mg once daily. Coadministration with moderate CYP2C8 inhibitors: Reduce dose to 80 mg daily for patients weighing ≥100 kg, or reduce dose to 60 mg daily for patients weighing <100 kg

Quantity Limits: One tablet daily (all strengths – 60, 80 & 100 mg)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 12 months

- ❑ Member is 18 years of age or older
- ❑ Medication is prescribed by or in consultation with a specialist in the area of the member's diagnosis (e.g., hepatologist, gastroenterologist, or endocrinologist)

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- ❑ Member has a diagnosis of nonalcoholic steatohepatitis or metabolic dysfunction–associated steatohepatitis (NASH/MASH) **AND ALL** the following:
  - ❑ The member has stage F2 or F3 Fibrosis **AND <u>ONE</u>** of the following:
    - ❑ A liver biopsy showing fibrosis stage F2 or F3 (please attach documentation of the liver biopsy that was done with results) **OR**
    - ❑ A non-invasive liver test showing fibrosis stage F2 or F3 (please attach documentation of the non-invasive liver test that was done with the results)
      - ❑ Vibration-controlled transient elastography (VCTE)
      - ❑ Enhanced liver fibrosis (ELF)
      - ❑ Magnetic resonance elastography (MRE)
- ❑ Member has adopted liver-protective lifestyle interventions such as optimizing weight loss, dietary changes, and exercise
- ❑ Member does **<u>NOT</u>** have significant alcohol consumption (alcohol consumption of more than 20 g per day for women and more than 30 g per day for men) for a period of 3 consecutive months within 1 year prior to screening.
- ❑ Member does **<u>NOT</u>** have evidence of decompensated cirrhosis or moderate to severe hepatic impairment (Child-Pugh Class B or C) **(must submit documentation)**

<u>Reauthorization</u>: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member continues to meet **<u>ALL</u>** initial authorization criteria
- ❑ Member continues to experience clinical benefit from the therapy.

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

***Approved by Pharmacy and Therapeutics Committee**: 5/23/2024
REVISED/UPDATED/REFORMATTED: ~~5/20/2024; 6/6/2024 9/26/2025, 2/1/2026;~~ **4/3/2026**