US Family Health Plan

Prior Authorization Request Form for

Resmetirom (Rezdiffra)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Clinical documentation may be required for approval.
Prior authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.*	☐ Yes (subject to verification) Proceed to question **7**	☐ No Proceed to question **2**
2. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Is the requested medication prescribed by or in consultation with a hepatologist or gastroenterologist?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Does the patient have biopsy-proven non-alcoholic steatohepatitis (NASH)?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Does the patient have fibrosis stage of F2 or F3, diagnosed with appropriate assessment (for example, FibroScan, MRI-PDFF)?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved

6. Does the patient have metabolic risk factors that are managed by standard of care (for example, lifestyle modifications, glucagon-like peptide 1-receptor agonists (semaglutide, tirzepatide), or statins)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
7. Does the patient have documentation of positive clinical response to include improvement in fibrosis or stabilization of fibrosis?	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved
8. Does the patient continue to have consultation with a hepatologist or gastroenterologist?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____