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**

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:**

Question		
1. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Is the requested medication prescribed by or in consultation with a hepatologist or gastroenterologist?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Does the patient have biopsy-proven non-alcoholic steatohepatitis (NASH)?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Does the patient have fibrosis stage of F2 or F3 confirmed by MRI?	☐ Yes	☐ 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