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AETNA BETTER HEALTH® OF VIRGINIA REQUES

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) 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**
   - ONE of the following:
     - The member is ≤ 65 years of age and has a Fibrosis Index Based on 4 Factors (FIB-4) score > 1.3; **OR**
     - The member is > 65 years of age and has a FIB-4 score > 2; **AND**
   - The member has ONE of the following:
     - A liver biopsy showing fibrosis stage 2 or 3; OR
     - At least ONE of the following:
       - Vibration-controlled transient elastography (VCTE, e.g., Fibroscan) score > 8.1
       - Enhanced liver fibrosis (ELF) score > 7.7
       - Magnetic resonance elastography (MRE) score > 2.6?

   ☐ 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?
   ☐ Yes ☐ No
7. Does the member continue to experience clinical benefit from the requested treatment?
   ☐ Yes ☐ No

Prescriber Signature (Required)
By signature, the Physician confirms the above information is accurate and verifiable by member records.

Date

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:
Prime Therapeutics Management LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811