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New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form

Rezdiffra® (resmetirom)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME: **FIRST NAME:**

MEDICAID ID NUMBER: **DATE OF BIRTH:** – –

GENDER: ☐ Male ☐ Female

Drug Name: **Strength:**

Dosing Directions: **Length of Therapy:**

SECTION II: PRESCRIBER INFORMATION

LAST NAME: **FIRST NAME:**

SPECIALTY: **NPI NUMBER:**

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY:

1. Is the prescriber a gastroenterologist or hepatologist or has one been consulted? ☐ Yes ☐ No
2. Does the patient have a diagnosis of noncirrhotic nonalcoholic steatohepatitis? ☐ Yes ☐ No
3. Does the patient have moderate to advance liver fibrosis determined by at least one of the following? (Check all that apply.)

   ☐ Liver biopsy in the last 2 years confirming steatosis and one of the following:

   - Nonalcoholic fatty liver disease (NAFLD) activity score (NAS) 4 or more
   - Score 1 or higher in each NAS component
   - Fibrosis stage 1, 2, or 3

   ☐ Vibration-controlled transient elastography with 8.4 or more kPA and controlled attenuation parameter score 280 or more dB/m

☐ Magnetic resonance elastography (MRE) 2or more and less than 4

☐ Historical biochemical test for fibrosis:

- PRO-C3 >14 ng/mL
- Enhanced liver fibrosis score 9 or more

4. Does the patient have a magnetic resonance imaging proton density fat fraction (MRI-PDFF) 8% or more liver fat? ☐ Yes ☐ No

5. Is the patient currently receiving a statin with no plans for discontinuation? ☐ Yes ☐ No
   If not, please provide justification: _____

6. Has the patient implemented lifestyle modifications to enhance diet and exercise? ☐ Yes ☐ No

7. Does the patient have any of the following? (Check all that apply.)
   ☐ History of significant alcohol consumption for more than 3 consecutive months in the last 12 months
   ☐ Hepatocellular carcinoma
   ☐ Other liver disease: _____
   ☐ Model for end-stage liver disease (MELD) score 12 or higher unless due to therapeutic anticoagulation
   ☐ History of bariatric surgery in last 12 months

8. Is the patient currently taking a strong cytochrome P450 2C8 inhibitor? ☐ Yes ☐ No

9. Is the patient currently taking an organic anion-transporting polypeptides (OATP) 1B1 or OATP 1b3 inhibitor? ☐ Yes ☐ No

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PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(Continued)*

10. Provide any additional information that would help in the decision-making process.
    If additional space is needed, please use a separate sheet.

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

Phone: 1-866-675-7755
Fax: 1-888-603-7696

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