



**New Hampshire AIDS Drug Assistance Program
Prior Authorization Drug Approval Form**

Rezdiffra® (resmetirom)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER: Male Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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SECTION III: CLINICAL HISTORY:

- Is the prescriber a gastroenterologist or hepatologist or has one been consulted? Yes No
- Does the patient have a diagnosis of noncirrhotic nonalcoholic steatohepatitis? Yes No
- 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



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- Magnetic resonance elastography (MRE) 2 or 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:

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PATIENT FIRST NAME:

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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:** _____