



**MEDICAID / CHIP**  
**PHARMACY PRIOR AUTHORIZATION REQUEST FORM**

**Rezdifra - Non-PDL**

**Phone: 866-841-7659**

**Fax back to: 866-240-3712**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

Member Name:		Prescriber Name:	
Member ID Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Phone Number:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..</i>			

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

***Please answer the following questions and sign.***

Q1. Is this a request for renewal?

Yes

No

Q2. Is the patient prescribed a dose and duration of therapy consistent with the FDA approved package labeling?

Yes

No

Q3. Will the patient follow a reduced-calorie diet and increased physical activity plan?

Yes

No

Q4. For a diagnosis of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH), does the patient have any of the following?

Hepatic decompensation or a Model for End-Stage Liver Disease (MELD) score of more than 12 points at screening

Significant alcohol consumption (> 20 grams of alcohol per day for women and > 30 grams for men)

An aspartate aminotransferase (AST) or alanine aminotransferase (ALT) level of more than 5 times the upper limit of the normal range at screening



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<input type="checkbox"/> Diagnosis of hepatocellular carcinoma (HCC) <input type="checkbox"/> Chronic liver diseases (e.g., primary biliary cholangitis, primary sclerosing cholangitis, Hepatitis B positive, Active Hepatitis C, etc.)
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<p>Q11. Is there a diagnosis of noncirrhotic nonalcoholic steatohepatitis (NASH) confirmed by liver biopsy or imaging confirming steatosis with results attached? (Imaging studies can include ultrasound, Fibroscan CAP, or MRI-PDFF).</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
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<p>Q12. For a diagnosis of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH), does the patient have any of the following?</p> <p><input type="checkbox"/> Hepatic decompensation or a Model for End-Stage Liver Disease (MELD) score of more than 12 points at screening</p> <p><input type="checkbox"/> Significant alcohol consumption (&gt; 20 grams of alcohol per day for women and &gt; 30 grams for men)</p> <p><input type="checkbox"/> An aspartate aminotransferase (AST) or alanine aminotransferase (ALT) level of more than 5 times the upper limit of the normal range at screening</p> <p><input type="checkbox"/> An estimated glomerular filtration rate (eGFR) of less than 30ml/min/1.73 m2</p> <p><input type="checkbox"/> Presence or history of hepatocellular carcinoma (HCC)</p> <p><input type="checkbox"/> History of acute pancreatitis</p> <p><input type="checkbox"/> Chronic liver diseases other than metabolic dysfunction-associated steatotic liver disease (MASLD) (e.g., primary biliary cholangitis, primary sclerosing cholangitis, Hepatitis B positive, Active Hepatitis C, etc.)</p>
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<p>Q13. Does the patient have moderate to advanced liver fibrosis (stages F2 or F3) confirmed by liver biopsy performed within the last 6 months?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
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<p>Q14. Does the patient have moderate to advanced liver fibrosis (stage F2 or F3) confirmed by ONE of the following non-invasive tests performed within the last 6 months:</p> <p><input type="checkbox"/> Transient elastography (e.g., Fibroscan)</p> <p><input type="checkbox"/> Shear wave elastography (SWE)</p> <p><input type="checkbox"/> Magnetic resonance elastography (MRE)</p>
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Q15. Is the patient prescribed a dose and duration of therapy consistent with the FDA approved package labeling? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q16. Will the patient follow a reduced-calorie diet and increased physical activity plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q17. Is there documentation of counseling the patient on dietary and lifestyle modifications? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q18. Additional Information: <input type="checkbox"/> Yes <input type="checkbox"/> No

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2026-06