BlueCross BlueShield Federal Employee Program®

REZDIFFRA
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Rezdiffra
(resmetirom)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Will the patient need more than 100 milligrams per day? ❑Yes* ❑No
   If YES, please specify the requested milligrams per day: _____ mg per day
2. Does the patient have a diagnosis of noncirrhotic nonalcoholic steatohepatitis (NASH)? ❑Yes ❑No
3. Has the patient had significant alcohol consumption (greater than or equal to 2 alcoholic drinks per day) for a duration of more than three months in the last year? ❑Yes ❑No
4. Does the patient have a diagnosis of hepatocellular carcinoma (HCC)? ❑Yes ❑No
5. Does the patient have any chronic liver diseases (e.g., primary biliary cholangitis, primary sclerosing cholangitis, Hepatitis B positive, active Hepatitis C, etc.)? ❑Yes ❑No
6. Will this medication be used in conjunction with diet and exercise? ❑Yes ❑No
7. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Does the patient have THREE or more of the following conditions that are managed according to standard of care: central obesity, hypertriglyceridemia, reduced high-density lipoprotein cholesterol (HDL), hypertension, or elevated fasting plasma glucose (i.e., diabetes or pre-diabetes)? ❑Yes ❑No

b. Does the patient have stage F4 liver fibrosis (cirrhosis)? ❑Yes ❑No

c. Does the patient have moderate to advanced liver fibrosis (stages F2 to F3)? ❑Yes* ❑No

If YES, has the moderate to advanced liver fibrosis been confirmed by a liver biopsy performed within the last 6 months? ***Please select answer below and answer the following questions:***

❑**Yes:** Does the patient have a Nonalcoholic Fatty Liver Disease Activity score (NAS) greater than or equal to 4?
- ❑Yes, NAS greater than or equal to 4.
- ❑No, NAS less than 4. ***Please answer below question:***
  i. Is there a presence of hepatocyte ballooning and steatosis? ❑Yes ❑No
- ❑No, NAS has not been obtained.

❑**No:** Has the moderate to advanced liver fibrosis been confirmed by elastography (e.g., Fibroscan), computed tomography, or magnetic resonance imaging within the last 3 months? ❑Yes ❑No

d. Is this medication being prescribed by or in consultation with an endocrinologist, gastroenterologist, or hepatologist? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. Are the metabolic risks managed to standard of care? ❑Yes ❑No

b. Has the patient progressed to stage F4 (cirrhosis)? ❑Yes ❑No

c. Has there been an improvement in fibrosis by at least 1 stage within 1 year of treatment? ❑Yes ❑No

d. Has the patient had worsening of fibrosis after 2 years or more of therapy? ❑Yes ❑No