Health Partners
A part of Jefferson Health Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Rezdiffra - Non PDL

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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.

Patient Name:	Prescriber Name:	
HPP HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

HPP's maximum approval time is 12 months but may be less depending on the drug.

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? If YES, go to question 2. If NO, go to question 4

☐ Yes ☐ No

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

☐ Yes ☐ No

Q3. Is there documentation of positive clinical response and tolerability to requested medication?

☐ Yes ☐ No

Q4. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q5. Is the medication prescribed by or in consultation with a hepatologist or gastroenterologist?

☐ Yes ☐ No

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Q6. Is there a confirmed diagnosis of noncirrhotic nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) by ALL the following:

a. Liver biopsy or imaging (ultrasound, Fibroscan CAP, MRI-PDFF) confirming steatosis with documentation provided.

b. Moderate to advanced liver fibrosis (stages F2 or F3 fibrosis) confirmed by ONE of the following performed within the last 6 months: (i) Liver biopsy confirming fibrosis F2 or F3; OR (ii) FIB-4 = 1.3 AND one of the following non-invasive tests are consistent with F2 or F3 fibrosis: (Transient elastography y (e.g., Fibroscan), Shear wave elastography (SWE), Magnetic resonance elastography (MRE)).

☐ Yes ☐ No

Q7. Is the patient prescribed a dose and duration of therapy consistent with the FDA approved package labeling?

☐ Yes ☐ No

Q8. Is there evidence of cirrhosis (stage F4 fibrosis) by imaging or liver biopsy or one or more liver related complications associated with cirrhosis (ex: variceal bleeding, ascites hepatic encephalopathy)?

☐ Yes ☐ No

Q9. Is there documentation of significant alcohol use (defined as alcohol consumption of more than 1 drink/day for females or more than 2 drinks/day for males)?

☐ Yes ☐ No

Q10. Is there documentation of counseling the patient on dietary and lifestyle modifications?

☐ Yes ☐ No

Q11. Additional Information:

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

_____ _____

Prescriber Signature Date

v2024