Prescriber Criteria Form Rezdiffra 2026 PA Fax 6462-A v1 010126.docx Rezdiffra (resmetirom) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Rezdiffra (resmetirom).

Drug Name: Rezdiffra (resmetirom)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of non-cirrhotic nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis (consistent with stages F2 to F3)? [If no, then no further questions.]	Yes	No
2	Is the patient currently receiving therapy with the requested medication? [If yes, then skip to question 4.]	Yes	No
3	Does the patient have stage F2 to F3 liver fibrosis at baseline confirmed by liver biopsy or magnetic resonance elastography (MRE)? [If yes, then skip to question 5.] [If no, then no further questions.]	Yes	No
4	Has the patient demonstrated a beneficial response to therapy (for example, improvement in liver function such as reduction in alanine aminotransferase (ALT), reduction of liver fat content by imaging such as magnetic resonance imaging-protein density fat fraction (MRI-PDFF) or FibroScan controlled attenuation parameter (CAP))? [If no, then no further questions.]	Yes	No
5	Is the requested drug being prescribed by, or in consultation with, a gastroenterologist or hepatologist?	Yes	No

Comments:	

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____