

RESMETIROM PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today's Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:		Patient Telephone:
Member ID Number:		Group Number:	

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Phone #:	Secure Fax #:

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis <input type="checkbox"/> Noncirrhotic nonalcoholic steatohepatitis (NASH) <input type="checkbox"/> Metabolic dysfunction associated steatohepatitis (MASH) <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests: 1. Is the patient currently being treated with the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient currently stable on the requested agent? Please note, chart notes are required. <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Does the patient have any FDA labeled contraindications to the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindications: _____ _____	
3. Is the patient's age within FDA labeling for the requested indication for the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, is there support for using the requested agent for the patient's age for the requested indication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide supporting information: _____ _____	
4. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., hepatologist, gastroenterologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Is the patient currently on a weight management regimen of a low-calorie diet, increased physical activity, and behavioral modifications?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, will the patient continue the weight management regimen in combination with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). Please note, documentation may be required: _____ _____ _____	
Please continue to the next page.	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
-----------------------	-------	----	-------------------

For noncirrhotic nonalcoholic steatohepatitis (NASH) or metabolic dysfunction associated steatohepatitis (MASH) requests:

7. Are there medical records to confirm the noncirrhotic nonalcoholic steatohepatitis (NASH) or metabolic dysfunction associated steatohepatitis (MASH) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis)? **Please note, medical records are required**..... Yes No
8. Are there medical records that show the patient has stage F2 or F3 fibrosis as confirmed by ONE of the following (prior to therapy with the requested agent):
 - A liver biopsy within the past 2 years
 - Vibration-controlled transient elastography (VCTE)
 - Enhanced liver fibrosis (ELF) score
 - Magnetic resonance elastography (MRE) Yes No

If yes, please submit medical records.
9. Is the patient being monitored and/or treated for any comorbid conditions (e.g., cardiovascular disease, diabetes, dyslipidemia, hypertension)? Yes No
10. If the patient is a female, are there medical records showing the patient's alcohol consumption is less than 20 grams per day? (Note: one standard alcoholic drink contains roughly 14 grams of pure alcohol, which is found in 12 ounces of regular beer, 5 ounces of wine, or 1.5 ounces of distilled spirits) Yes No
11. If the patient is a male, are there medical records showing the patient's alcohol consumption is less than 30 grams per day? (Note: one standard alcoholic drink contains roughly 14 grams of pure alcohol, which is found in 12 ounces of regular beer, 5 ounces of wine, or 1.5 ounces of distilled spirits) Yes No
12. Are there medical records showing the patient does NOT have any of the following: decompensated cirrhosis, moderate to severe hepatic impairment (Child-Pugh Class B or C), any other liver disease (e.g., Wilson's disease, hepatocellular carcinoma, hepatitis)? Yes No
13. Has the patient tried and had an inadequate response after 72 weeks of therapy with Wegovy? Yes No

If no, has the patient tried and had an inadequate response after 72 weeks of therapy with another subcutaneous GLP-1 agent for the treatment of the requested indication? Yes No

If no, was a subcutaneous GLP-1 agent used for the treatment of the requested indication discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

If no, does the patient have an intolerance or hypersensitivity to therapy with Wegovy? Yes No

If no, does the patient have an FDA labeled contraindication to Wegovy? Yes No
14. If no to all of question 14, is Wegovy expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No

Is Wegovy not in the best interest of the patient based on medical necessity? Yes No

Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as Wegovy and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

Is the patient of South Asian, Southeast Asian, or East Asian descent? Yes No

If yes, does the patient have a BMI less than or equal to 23 kg/m²? Yes No

If no, does the patient have a BMI less than or equal to 25 kg/m²? Yes No

For renewal requests:

15. Has the patient had clinical benefit with the requested agent? Yes No

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the

Phone:

BCBSIL: 800.285.9426

BCBSMT: 888.723.7443

BCBSNM: 800.544.1378

BCBSOK: 800.991.5643

BCBSTX: 800.289.1525

Fax: 877.243.6930

intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.