HIGHMARK HEALTH OPTIONS

Updated: 03/2026
DMMA Approved: 04/2026

Request for Prior Authorization for Noncirrhotic metabolic dysfunction– associated steatohepatitis (MASH) Agents

Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Noncirrhotic metabolic dysfunction– associated steatohepatitis (MASH) Agents require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Noncirrhotic metabolic dysfunction– associated steatohepatitis (MASH) Agents include: Rezdiffra (resmetirom).

NOTE: For a request for a drug containing a glucagon-like peptide-1 (GLP-1) receptor agonist for the diagnosis of Noncirrhotic metabolic dysfunction– associated steatohepatitis (MASH), please refer to policy CP-206.380 -MD-DE GLP Receptor Agonist.

Noncirrhotic metabolic dysfunction– associated steatohepatitis (MASH) Agents Prior Authorization Criteria:

Coverage may be provided with a diagnosis of noncirrhotic metabolic dysfunction– associated steatohepatitis (MASH) and all of the following criteria is met:

- Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- Must be prescribed by or in consultation with a hepatologist or gastroenterologist
- Documentation the member has received lifestyle counseling on nutrition and exercise and will continue to use in conjunction with the requested medication
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Documentation of a confirmed diagnosis of MASH with fibrosis stage 2 or 3 confirmed by **one** of the following within the last 6 months:
    - Liver biopsy confirming steatosis AND ALL of the following:
        - NAFLD Activity Score (NAS) of at least 4
        - A score of at least 1 in each NAS component [i.e., steatosis (scored 0 to 3), ballooning degeneration (scored 0 to 2), lobular inflammation (scored 0 to 3)]
    - One of the following assessments:
        - Serum-based assessment (e.g., fibrosis-4 [FIB-4], NAFLD fibrosis score [NFS], enhanced liver fibrosis test [ELF] greater than or equal to 9);

  - imaging-based assessment (e.g., FibroScan, VCTE with kPa greater than or equal to 8.5, magnetic resonance-based elastography [MRE], magnetic resonance imaging–proton density fat fraction [MRI-PDFF] greater than or equal to 8% liver fat);
  - FAST score, as measured by FibroScan and serum aspartate aminotransferase (AST);
  - MAST score, as measured by MRI-PDFF, MRE, and serum AST;
  - MEFIB score, as measured by FIB-4 and MRE

- Member must not have any of the following exclusions:
  - Thyroid diseases including:
    - Active hyperthyroidism
    - Untreated clinical hypothyroidism defined by thyroid stimulating hormone (TSH) >7 IU/L with symptoms of hypothyroidism or >10 IU/L without symptoms
  - Recent significant weight gain or loss
  - HbA1c ≥ 9.0%
  - Presence of cirrhosis on liver biopsy defined as stage 4 fibrosis
  - Diagnosis of hepatocellular carcinoma (HCC)
  - MELD score ≥12, unless due to therapeutic anti coagulation
  - Hepatic decompensation
  - Chronic liver diseases other than MASH
  - History of bariatric surgery (within the past 5 years)
  - Active autoimmune disease
  - Serum ALT > 250 U/L
  - Active, serious medical disease with a likely life expectancy less than 2 years
  - History of significant alcohol consumption for a period of more than 3 consecutive months within 1 year prior to starting requested therapy
- The member must discontinue use of any medication that may affect NAS or fibrosis stage or regular use of drugs historically associated with NAFLD
- Member has at least 2 metabolic risk factors (e.g., obesity, type 2 diabetes, dyslipidemia, hypertension)

- **Initial Duration of Approval:** 6 months

- **Reauthorization criteria:**
  - The member has received a clinical benefit demonstrated by either:
    - the resolution of steatohepatitis and no worsening of liver fibrosis or
    - at least one stage improvement in liver fibrosis and no worsening of steatohepatitis
  - The member has documentation of an annual evaluation, including laboratory values since starting treatment, by a hepatologist or gastroenterologist
  - Documentation the member continues to diet and exercise in conjunction with the requested medication

  - The member continues to not use any medication that may affect NAS or fibrosis stage or regular use of drugs historically associated with NAFLD
  - The member does not have any exclusions as listed in the initial review criteria
- **Reauthorization Duration of Approval**: 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

HIGHMARK HEALTH OPTIONS

Updated: 03/2026
DMMA Approved: 04/2026

NONCIRRHOTIC METABOLIC DYSFUNCTION– ASSOCIATED STEATOHEPATITIS (MASH) AGENTS PRIOR AUTHORIZATION FORM- PAGE 1 of 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:00am to 7:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

BILLING INFORMATION

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:)

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

PLACE OF SERVICE INFORMATION

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: ☐ Noncirrhotic metabolic dysfunction– associated steatohepatitis (MASH) ☐ Other: _____
What is the members liver fibrosis score:
How was the diagnosis confirmed (check all that apply-**submit chart documentation**)?
☐ Liver biopsy including NAFLD Activity Score (NAS) of at least 4 AND a score of at least 1 in each NAS component [i.e., steatosis (scored 0 to 3), ballooning degeneration (scored 0 to 2), lobular inflammation (scored 0 to 3)]
One of the following assessments:
☐ Imaging based assessment: vibration-controlled transient elastography (VCTE; e.g FibroScan) with kPa greater than or equal to 8.5, MRI-PDFF greater than or equal to 8% liver fat included MRE
☐ Serum-based assessment: fibrosis-4 [FIB-4], NAFLD fibrosis score [NFS], Enhanced Liver Fibrosis (ELF) greater than or equal to 9
☐ FAST score- measured by FibroScan and serum aspartate aminotransferase (AST)
☐ MAST score- measure by MRI-PDFF, MRE and serum AST
☐ MEFIB score- measured by FIB-4 and MRE
Does the member have any of the following (check all that apply):
☐ Thyroid diseases including active hyperthyroidism or untreated clinical hypothyroidism defined by thyroid stimulating hormone (TSH) >7 IU/L with symptoms of hypothyroidism or >10 IU/L without symptoms
☐ Recent significant weight gain or loss
☐ HbA1c ≥ 9.0%
☐ Presence of cirrhosis on liver biopsy defined as stage 4 fibrosis
☐ Diagnosis of hepatocellular carcinoma (HCC)
☐ MELD score ≥12, unless due to therapeutic anti coagulation
☐ Hepatic decompensation
☐ Chronic liver diseases other than MASH

(*** continued on next page**)

HIGHMARK HEALTH OPTIONS

Updated: 03/2026
DMMA Approved: 04/2026

NONCIRRHOTIC METABOLIC DYSFUNCTION– ASSOCIATED STEATOHEPATITIS (MASH) AGENTS PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (855) 476-4158**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon – Fri 8 am to 7 pm

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

MEDICAL HISTORY (Complete for ALL requests)- continued

☐ Active autoimmune disease
☐ History of bariatric surgery (within the past 5 years)
☐ Serum ALT > 250 U/L
☐ Active, serious medical disease with a likely life expectancy less than 2 years
☐ History of significant alcohol consumption for a period of more than 3 consecutive months within 1 year prior to starting requested therapy

Will the member be monitored for elevations in liver tests and development of liver related adverse reactions: ☐ Yes ☐ No
Has the member discontinued any medication that may affect NAS or fibrosis stage or regular use of drugs historically associated with NAFLD? ☐ Yes ☐ No
Is there documentation the member has received lifestyle counseling on nutrition and exercise and will continue to use in conjunction with the requested medication? ☐ Yes ☐ No
Does the member have at least two (2) metabolic risk factors (e.g. obesity, type 2 diabetes, dyslipidemia, hyptersion, etc)? ☐ Yes ☐

REAUTHORIZATION

Has the member received a clinical benefit demonstrated by either resolution of steatohepatitis and no worsening of liver fibrosis or at least one stage improvement in liver fibrosis and no worsening of steatohepatitis? ☐ Yes ☐ No
Is there documentation of an annual evaluation, including laboratory values since starting treatment, by a hepatologist or gastroenterologist? ☐ Yes ☐ No
Is there documentation the member continues to diet and exercise in conjunction with the requested medication? ☐ Yes ☐ No
Does the member continue to not use any medication that may affect NAS or fibrosis stage or regular use of drugs historically associated with NAFLD? ☐ Yes ☐ No
Does the member have any exclusions to the requested medication? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date