

Prior Authorization Form: GLP1 Receptor Agonists for Metabolic Dysfunction-Associated Steatohepatitis (MASH)

Virginia | HealthKeepers, Inc. | Anthem HealthKeepers Plus Medicaid products

If the following information is not complete, correct, or legible, the prior authorization (PA) process can be delayed. Please use one form per member.

Member information

Last name		First name	
Medicaid ID No.		DOB	
Weight (kg)			

Prescriber information

Last name		First name	
NPI No.			
Phone No.		Fax No.	

Drug information

For initial requests, continue below. For renewal requests, proceed to the next page. If approved, initial authorizations are granted for six months. Renewal authorizations are granted for 12 months.

Drug name		Drug form	
Drug strength		Dosing frequency	
Length of therapy		Quantity	
Day supply			

- FDA indicated medications only
- Must be prescribed by or in consultation with a hepatologist, gastroenterologist, or other provider specializing in liver disease for the member to receive authorization

Member information (repeated)

Last name		First name	
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Diagnosis and medical information

- The member is 18 years of age or older; **and**
- The member's baseline or recent liver biopsy demonstrates clinically significant MASLD (metabolic dysfunction-associated steatotic liver disease) by at least **one** of the following:
 - Histological evidence of MASH; **or**
 - NASH Clinical Research Network score consistent with fibrosis stage F2 or F3; **or**
 - Nonalcoholic fatty liver disease activity score ≥ 4 with a score of ≥ 1 in each: steatosis, lobular inflammation, and hepatocyte ballooning; **and**
- The member has a BMI ≥ 18.5 kg/m²; **and**
- The provider attests that the member received individualized healthy lifestyle counseling; **and**
- The member does not have an A1C of $>9.5\%$; **and**
- The member does not have known or suspected excessive consumption of alcohol; **and**
- The member does not have hepatic decompensation or a MELD score of >12 at screening; **and**
- The member does not have pancreatitis, acute suicidal behavior/ideation, personal or family history of medullary thyroid cancer or multiple endocrine neoplasia 2 syndrome. **and**
- The member is not concurrently on another GLP-1 receptor agonist
- Check if additional documents will be uploaded

Length of authorization

Renewal request (see additional requirements below):

- The member has experienced a clinical improvement on the requested medication
- The member is being treated with a maintenance dosage of the requested drug

Prescriber signature

Date

By signing, the physician confirms that the above information is accurate and verifiable by member records.

Please include **all** requested information and answer **all** questions. If the provider is unable to attest, a denial of coverage will be rendered. Incomplete forms will delay the PA process. Submission of documentation **does not** guarantee coverage. The completed form may be faxed to **844-512-7020**.