

Date Shipment Needed: \_\_\_\_\_ Ship To:  Patient  Prescriber

**MASH REFERRAL FORM**

**PATIENT INFORMATION**

|                    |        |            |  |         |  |
|--------------------|--------|------------|--|---------|--|
| Patient Name:      |        | DOB:       | Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other: | Weight: | <input type="checkbox"/> lbs. <input type="checkbox"/> kg. |
| SSN:               | Phone: | Allergies: |  |         |  |
| Address:           |        | City:      | State:   | Zip:    |  |
| Emergency Contact: |        | Phone:     | <input type="checkbox"/> Please attach demographic information                             |         |  |

**PRESCRIBER INFORMATION**

|                        |      |                     |        |            |  |
|------------------------|------|---------------------|--------|------------|--|
| Prescriber:            |      | NPI:                | DEA:   | State Lic: |  |
| Supervising Physician: |      | Practice Name:      |        |            |  |
| Address:               |      | City:               | State: | Zip:       |  |
| Phone:                 | Fax: | Key Office Contact: |        | Phone:     |  |

**DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT**

**Primary Diagnosis:**  NASH (MASH) K75.81  Other: \_\_\_\_\_

▪ Please list ALL MEDS below that patient has tried and failed for dx including any OTC medications: \_\_\_\_\_

**CLINICAL INFORMATION REQUIRED**

▪ **Please attach the following Clinical Information:**

|   |   |   |
|---|---|---|
| <input type="checkbox"/> Clinical Notes pertaining to NASH (MASH) diagnosis   | <input type="checkbox"/> Fibrosis score with relevant imaging such as: FibroScan, FibroSURE, MRE, Liver Biopsy, FIB-4, ELF Score, MAST, MEFIB | <input type="checkbox"/> History and management of metabolic risk factors such as: diabetes / pre-diabetes, obesity, hypertension, hypertriglyceridemia |
| <input type="checkbox"/> Current medication list (including diabetes medications and any thyroid agents)                        | <input type="checkbox"/> Current diet and exercise plan and/or participation in weight management program                                     | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Recent labs (drawn within the past 90 days) that include CBC, CMP and liver function results (ALT/AST) | <input type="checkbox"/> Current weight   | _____   |
| <input type="checkbox"/> If previously treated for MASH, date and type of therapy   |   | _____   |

**INSURANCE INFORMATION**

Please attach front and back of patient's insurance card (medical and prescription)

**COPAY CARD ENROLLMENT**

Please check if enrolling in copay card      Copay ID: \_\_\_\_\_

**PRESCRIPTION INFORMATION**

**Rezdiffra™** 60 mg, 80 mg and/or 100 mg Tablets

|  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Actual BW < 100 kg: 80 mg PO once daily with or without food  | QTY: _____ 30 _____   Refills: _____ |
| <input type="checkbox"/> Actual BW ≥ 100 kg: 100 mg PO once daily with or without food | QTY: _____ 30 _____   Refills: _____ |

For CYP2C8 inhibitors (moderate medications such as Plavix)

|   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> Actual BW < 100 kg: 60 mg PO once daily with or without food | QTY: _____ 30 _____   Refills: _____ |
| <input type="checkbox"/> Actual BW ≥ 100 kg: 80 mg PO once daily with or without food | QTY: _____ 30 _____   Refills: _____ |

\* Concomitant use of Rezdiffra with strong CYP2C8 inhibitors (e.g., gemfibrozil/Lopid) is not recommended

Other: \_\_\_\_\_ QTY: \_\_\_\_\_ | Refills: \_\_\_\_\_

**Prescriber's Signature:** \_\_\_\_\_  DAW (Dispense as Written) **Date:** \_\_\_\_\_

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

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