Pharmacy Drug Policy & Procedure

Policy Name:	Rezdiffra (resmetirom)	Policy#:	3374P

Purpose of the Policy

The purpose of this policy is to define coverage criteria for Rezdiffra (resmetirom).

Statement of the Policy

Health Alliance Medical Plans will approve the use of Rezdiffra (resmetirom) under the specialty pharmacy benefit if the following criteria are met.

Criteria

1. Coverage Criteria

1.1 Diagnosis of noncirrhotic nonalcoholic steatohepatitis (liver disease) (NASH/MASH)
- Diagnosis confirmed by one of the following: liver biopsy, elastography (MRE or VCTE), magnetic resonance imaging (MRI), serum or imaging biomarker (Fibroscan, NFS, ELF)

1.2 Evidence of moderate to advanced liver fibrosis as evidenced by stages F2 to F3 fibrosis
1.3 Age 18 years or older
1.4 Prescribed by or in consultation with a hepatologist (liver doctor)
1.5 Evidence of additional conditions such as prediabetes or type 2 diabetes, obesity, hypertension, etc
1.6 Rezdiffra will be used in in addition to diet and exercise

2. Exclusion Criteria

2.1 Evidence of decompensated cirrhosis
2.2 F1 or F4 fibrosis
2.3 Evidence of significant alcohol consumption (defined as ≥20g/day for females or ≥30g/day for males)

3. Managed Dose Limit

3.1 #30 tablets per 30 days

4. Approval Period

4.1 Initial: 12 months
4.2 Reauthorization: 12 months with documented clinical benefit from therapy

CPT Codes	

HCPCS Codes	

References

1. Rezdiffra (resmetirom) [prescribing information]. West Conshohocken, PA: Madrigal Pharmaceuticals Inc; March 2024.

2. Harrison SA, Bedossa P, Guy CD, et al; MAESTRO-NASH Investigators. A Phase 3, Randomized, Controlled Trial of Resmetirom in NASH with Liver Fibrosis. N Engl J Med. 2024 Feb 8;390(6):497-509.
3. Chen VL, Morgan TR, Rotman Y, et al. Resmetirom therapy for metabolic dysfunction-associated steatotic liver disease: October 2024 updates to AASLD Practice Guidance. Hepatology 81(1):p 312-320, January 2025.

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