Phone: 800.511.5144 • Fax: 877.541.1503

Date Shipment Needed: _____ Ship To: ☐ Patient ☐ Prescriber

MASH REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ☐ M ☐ F ☐ Other:	Weight:	☐ lbs. ☐ kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	☐ **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:**

☐ Clinical Notes pertaining to NASH (MASH) diagnosis

☐ Current medication list *(including diabetes medications and any thyroid agents)*

☐ Recent labs *(drawn within the past 90 days)* that include CBC, CMP and liver function results (ALT/AST)

☐ If previously treated for MASH, date and type of therapy

☐ Fibrosis score with relevant imaging such as: FibroScan, FibroSURE, MRE, Liver Biopsy, FIB-4, ELF Score, MAST, MEFIB

☐ Current diet and exercise plan and/or participation in weight management program

☐ Current weight

☐ History and management of metabolic risk factors such as: diabetes / pre-diabetes, obesity, hypertension, hypertriglyceridemia, high cholesterol

☐ Other: _____

_____

_____

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

☐ Actual BW < 100 kg: 80 mg PO once daily with or without food — QTY: 30 | Refills: _____

☐ Actual BW ≥ 100 kg: 100 mg PO once daily with or without food — QTY: 30 | Refills: _____

For CYP2C8 inhibitors *(moderate medications such as Plavix)*

☐ Actual BW < 100 kg: 60 mg PO once daily with or without food — QTY: 30 | Refills: _____

☐ 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.