Clinical Policy: Resmetirom (Rezdiffra)

Reference Number: MDN.CP.PHAR.647
Effective Date: 4.1.25
Last Review Date: 10.25.26
Line of Business: Meridian Illinois Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Resmetirom (Rezdiffra™) is a thyroid receptor beta agonist.

FDA Approved Indication(s)

Rezdiffra is indicated in conjunction with diet and exercise for the treatment of adults with noncirrhotic nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis).

This indication is approved under accelerated approval based on improvement of NASH and fibrosis. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

Limitation(s) of use: Avoid use in patients with decompensated cirrhosis.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Rezdiffra is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Metabolic Dysfunction-Associated Steatohepatitis (must meet all)**:**

1. Diagnosis of metabolic dysfunction-associated steatohepatitis (MASH; formerly known as NASH);
2. Prescribed by or in consultation with a hepatologist or gastroenterologist;
3. Age ≥ 18 years;
4. MASH with stage F2 or F3 fibrosis is confirmed by one of the following (a or b):
   a. Liver biopsy within the last 3 years;
   b. Both of the following assessments within the last 6 months (i and ii; *see Appendix E for examples*):
      i. Serum-based assessment (e.g., fibrosis-4 [FIB-4], NAFLD fibrosis score [NFS], enhanced liver fibrosis test [ELF]);
      ii. Imaging-based assessment (e.g., vibration-controlled transient elastography [VCTE], magnetic resonance-based elastography [MRE], magnetic resonance imaging–proton density fat fraction [MRI-PDFF]);

5. Documentation supports member's participation in a physician-directed weight loss program that involves a reduced calorie diet, increased physical activity, and behavioral modification that meets both of the following (a and b):
   a. Been actively enrolled in a physician-directed weight loss program for at least the last 6 months;
   b. Will continue to be enrolled in a physician-directed diet and exercise program while concomitantly prescribed Rezdiffra;
6. Prescriber attestation that member is currently receiving standard of care management for concomitant related condition(s), including type 2 diabetes mellitus (T2DM), dyslipidemia, and hypertension (*see Appendix D*);
7. Rezdiffra is not prescribed concurrently with Wegovy®;
8. Dose does not exceed 1 tablet per day and one of the following (a or b):
   a. Actual body weight < 100 kg: 80 mg per day;
   b. Actual body weight ≥ 100 kg: 100 mg per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Metabolic Dysfunction-Associated Steatohepatitis (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B)*;
2. Member is responding positively to therapy as evidenced by, including but not limited to, improvement in any of the following parameters:
   a. Improvement in fibrosis ≥ 1-stage from baseline with no worsening of MASH (i.e., no worsening of hepatocellular ballooning, lobular inflammation, or steatosis);
   b. Resolution of MASH with no worsening of fibrosis;
   c. No increase in fibrosis stage and no worsening of MASH from baseline;

3. Member has not progressed to cirrhosis (stage F4);

4. Documentation that member is actively enrolled in a physician-directed program that involves a reduced calorie diet, increased physical activity, and behavioral modification adjunct to therapy;
5. Prescriber attestation that member is currently receiving standard of care management for concomitant related condition(s), including T2DM, dyslipidemia, and hypertension;
6. If request is for a dose increase, new dose does not exceed 1 tablet per day and one of the following (a or b):
   a. Actual body weight < 100 kg: 80 mg per day;
   b. Actual body weight ≥ 100 kg: 100 mg per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AASLD: American Association for the Study of Liver Diseases
ACE: angiotensin-converting enzyme
ARB: angiotensin receptor blocker
AST: serum aspartate aminotransferase
BMI: body mass index
DPP-4: dipeptidyl peptidase 4
ELF: enhanced liver fibrosis
FDA: Food and Drug Administration
FIB-4: fibrosis-4
GLP-1: glucagon-like peptide 1
MASH: metabolic dysfunction-associated steatohepatitis
MASLD: metabolic dysfunction–associated steatotic liver disease
NAFLD: nonalcoholic fatty liver disease
MRE: magnetic resonance elastography
NASH: non-alcoholic steatohepatitis
NFS: NAFLD fibrosis score
PCSK9: proprotein convertase subtilisin/kexin type 9
SGLT2: sodium-glucose co-transporter 2

T2DM: type 2 diabetes mellitus

VCTE: vibration-controlled transient elastography

Appendix B: Therapeutic Alternatives

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Wegovy® (semaglutide)	Initiate at 0.5 mg SC once weekly and titrate to achieve maintenance dose of 2.4 mg once weekly. If patients do not tolerate the maintenance dosage of 2.4 mg once weekly, the dosage can be decreased to 1.7 mg once weekly.	2.4 mg/week

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings
None reported

Appendix D: General Information
- In June 2023, the nomenclature describing NASH and nonalcoholic fatty liver disease (NAFLD) was changed by an international liver disease societies consensus to MASH and metabolic dysfunction-associated steatotic liver disease (MASLD), respectively.
- MASH is defined by the presence of ≥ 5% hepatic steatosis with inflammation and hepatocyte injury (hepatocyte ballooning), with or without evidence of liver fibrosis.
- Standard of care management for concomitant related conditions:
  - T2DM management may include metformin, glucagon-like peptide 1 (GLP-1) receptor agonist, sodium-glucose co-transporter 2 (SGLT2) inhibitor, sulfonylurea, dipeptidyl peptidase 4 (DPP-4) inhibitors, pioglitazone, or insulin.
  - Dyslipidemia management may include a statin, ezetimibe, fibrate, omega-3 fatty acids, or proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors.
  - Hypertension management may include an angiotensin-converting enzyme (ACE) inhibitor, angiotensin receptor blocker (ARB), calcium channel blocker, or a thiazide diuretic.

Appendix E: Serum- and Imaging-Based Liver Assessment
- Examples of liver assessment scores combining serum-based and imaging-based tests to help identify MASH:
  - 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

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MASH	Recommended dose is based on actual body weight: • < 100 kg: 80 mg PO daily • ≥ 100 kg: 100 mg PO daily	See dosing regimen

VI. Product Availability

Oral tablets: 60 mg, 80 mg, 100 mg

VII. References

1. Rezdiffra Prescribing Information. West Conshohocken, PA: Madrigal Pharmaceuticals; July 2026. Available at: https://www.madrigalpharma.com/wpcontent/uploads/2024/03/Prescribing-Information.pdf. Accessed August 24, 2026.
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3. American Diabetes Association Professional Practice Committee. Standards of Care in Diabetes-2026. Diabetes Care. 2026;49(Suppl 1):S1-S371.
4. Rinella ME, Neuschwander-Tetri BA, Siddiqui MS, et al. AASLD Practice guidance on the clinical assessment and management of nonalcoholic fatty liver disease. Hepatology. 2023;77(5):1797-1835.
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6. Kanwal F, Bril F, Wong VW, et al. Clinical care pathway for the risk stratification and management of patients with metabolic dysfunction-associated steatotic liver disease. Gastroenterology. 2026;171(1):164-183.
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9. Chen VL, Morgan TR, Rotman Y, et al. Resmetirom therapy for metabolic dysfunctionassociated steatotic liver disease: October 2024 updates to AASLD Practice Guidance. Hepatology. 2025;81(1):312-320.
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12. Younossi ZM, Kalligeros M, Wong VW, et al. Updated global consensus recommendations for risk stratification, treatment initiation, and response monitoring in metabolic dysfunctionassociated steatotic liver disease. Clin Gastroenterol Hepatol. 2026;24(9):2333-2347.
13. Cusi K, Abdelmalek MF, Apovian CM, et al. Metabolic dysfunction-associated steatotic liver disease (MASLD) in people with diabetes: The need for screening and early intervention. A consensus report of the American Diabetes Association. Diabetes Care 2025;48:1057-1082.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created from CP.PHAR.647 to comply with State PDL	3.16.26	
Removed redirections to Wegovy per state PDL	4.9.26	
4Q 2026 annual review: removed concurrent prescribing exclusion from continued therapy criteria; added that member has not progressed to cirrhosis for continued therapy; references reviewed and updated.	10.25.26	11.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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