Viberzi (eluxadoline) Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-512-9004 or Provider Help Desk at 800-454-3730.

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #:_____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
Viberzi (eluxadoline)	_____	_____	Specify: _____
7. Diagnosis: _____			

8. Approval criteria: Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.

Prior authorization is required for eluxadoline (Viberzi™). Only FDA approved dosing will be considered. Payment will be considered under the following conditions:

1. Patient meets the FDA approved age; **and**
2. Patient has a diagnosis of irritable bowel syndrome with diarrhea (IBS-D); **and**
3. Patient does **not** have any of the following contraindications to therapy:
    - Patient is without a gallbladder
    - Known or suspected biliary duct obstruction, or sphincter of oddi disease/dysfunction
    - Alcoholism, alcohol abuse, alcohol addiction or consumption of more than three alcoholic beverages per day
    - A history of pancreatitis or structural diseases of the pancreas (including known or suspected pancreatic duct obstruction)
    - Severe hepatic impairment (Child-Pugh Class C)

- Severe constipation or sequelae from constipation
- Known or suspected mechanical gastrointestinal obstruction; **and**

4. Patient has documentation of a previous trial and therapy failure at a therapeutic dose with **both** of the following:
    - A preferred antispasmodic agent (dicyclomine or hyoscyamine); **and**
    - A preferred antidiarrheal agent (loperamide).

If the criteria for coverage are met, initial authorization will be given for three months to assess the response to treatment. Requests for continuation therapy will require the following:

1. Patient has not developed any contraindications to therapy (defined above); **and**
2. Patient has experienced a positive clinical response to therapy as demonstrated by at least one of the following:
    a) Improvement in abdominal cramping or pain, and/or
    b) Improvement in stool frequency and consistency

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Non-preferred
☐ Viberzi

Treatment failures:
Antispasmodic Trial (dicyclomine or hyoscyamine):
Drug name and dose: _____ Trial dates: _____
Reason for failure: _____
Antidiarrheal trial (loperamide): Dose: _____ Trial dates: _____
Reason for failure: _____

Indicate if patient has any of the following contraindications to therapy: _____

Patient is without a gallbladder: ☐ No ☐ Yes
Known or suspected biliary duct obstruction, or sphincter of oddi disease/dysfunction: ☐ No ☐ Yes
Alcoholism, alcohol abuse, alcohol addiction, or consumption of more than three alcoholic beverages per day: ☐ No ☐ Yes
A history of pancreatitis or structural diseases of the pancreas (including known or suspected pancreatic duct obstruction): ☐ No ☐ Yes
Severe hepatic impairment (Child-Pugh Class C): ☐ No ☐ Yes
Severe constipation or sequelae from constipation: ☐ No ☐ Yes
Known or suspected mechanical gastrointestinal obstruction: ☐ No ☐ Yes

Renewal requests
Has patient developed any contraindications to therapy (defined above)?
☐ No ☐ Yes (document contraindications to therapy): _____

Has patient experienced a positive clinical response to therapy as demonstrated by at least one of the following?
☐ Improvement in abdominal cramping or pain

☐ Improvement in stool frequency and consistency

Possible drug interactions/conflicting drug therapies: _____

_____

_____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Important note: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*