FAX Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
ELUXADOLINE (VIBERZI™)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

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 3 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 3 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

Strength	Dosage Instructions	Quantity	Days Supply

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Request for Prior Authorization-*Continued*
ELUXADOLINE (VIBERZI™)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Diagnosis: _____

Treatment failures:

Antispasmodic Trial (dicyclomine or hyoscyamine):

Drug name & 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 3 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.

Prescriber signature (Must match prescriber listed above.)	Date of submission

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.*