



## **Request for Prior Authorization ELUXADOLINE (VIBERZI™)**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

**FAX Completed Form To** 1.833.404.2392

**Pharmacy Help Desk** 1.800.460.8988

**Prescriber Help Desk** 1.833.587.2012

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
- 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

ents would

b) Impi	rovement in stool f	requency and consistency.		
	d trials may be ove y contraindicated.	rridden when documented evider	nce is provided that	the use of these age
Non-Preferr	<u>red</u>			
☐ Viberzi				
	Strength	Dosage Instructions	Quantity	Days Supply
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## Request for Prior Authorization-Continued ELUXADOLINE (VIBERZI™)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

FAX Completed Form To 1.833.404.2392

Pharmacy Help Desk 1.800.460.8988

Prescriber Help Desk 1.833.587.2012

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 ther	ару:		
Patient is without a gallbladder:		☐ No	Yes
Known or suspected biliary duct obstruction, or sphincter of Oddi disease	e/dysfunction:	☐ No	Yes
Alcoholism, alcohol abuse, alcohol addiction, or consumption of more the beverages per day:	an 3 alcoholic	☐ No	Yes
A history of pancreatitis or structural diseases of the pancreas (including suspected pancreatic duct obstruction):	known or	☐ 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 ab	ove)?		
☐ No ☐ Yes (document contraindications to therapy):			
Has patient experienced a positive clinical response to therapy as c  Improvement in abdominal cramping or pain  Improvement in stool frequency and consistency	demonstrated	by at least	one of the following?
Possible drug interactions/conflicting drug therapies:			
Attach lab results and other documentation as necessary.			
criber signature (Must match prescriber listed above.)			

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.

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