



Request for Prior Authorization
ELUXADOLINE (VIBERZI™)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, 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 is 18 years of age or older; 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

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

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**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
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**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.*