PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Viberzi® (eluxadoline)

Member

Last Name: ____________________ First Name: ____________________

ID #: ____________________ DOB: ____________ Gender: ____________

Primary Care Physician: ____________________

Requesting Provider: ____________________ Prov. Phone: ____________ Prov. Fax: ____________

Provider Address: ____

Provider NPI: ____________________ Contact Name: ____________________

Provider Signature: ____________________ Date: ____________

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Viberzi 75 mg, 100mg Oral Tablets.

Start date (or date of next dose): ____________________

Date of last dose (if applicable): ____________________

Dosing frequency: ____________________

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of Irritable bowel Syndrome (IBS) with diarrhea
2. ≥ 18 years old.
3. Must have failed conventional treatment with at least two of the following: dietary changes, loperamide, an antispasmodic (ex. Dicyclomine) or a bile acid sequestrant (cholestyramine, colestipol or colesevelem).

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 09/2017

Last reviewed 11/2018

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Irritable bowel Syndrome (IBS) with diarrhea
☐ *Other – the patient's condition is:* ______________________________
Rationale for use: ______________________________

B. Is the patient ≥ 18 years old?

☐ Yes
☐ No
Rationale for use: ______________________________

C. Which of the following has the patient tried?

☐ Loperamide
Dose:____________________ Dates: ______________
Outcome:____

☐ An antispasmodic (ex: dicyclomine)
Drug/dose:__________________ Dates:_______________
Outcome:____

☐ A bile acid sequestrant (ex: cholestyramine, colestipol or colesevelem)
Drug/dose:__________________ Dates:______________
Outcome:____

☐ Dietary Changes
Change made: ________________ Dates:______________
Outcome:____

☐ Other (please explain):____
____

☐ Not all requirements are met – Below is rationale for use:
____
____

Additional information

Note: Maximum covered dose is 200 mg/day.

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