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. Must be at least 18 years old
3. Must have failed conventional treatment with lifestyle and dietary modification which may include; exclusion of gas-producing foods, diet low in fermentable oligo-, di-, and monosaccharides and polyols (FODMAPs), and in select cases avoidance of lactose and gluten (detailed documentation of lifestyle changes tried for at least 1 month must be faxed to Priority Health)
4. Trial of at least three of the following (tried for at least 1 month each):
    a. Loperamide
    b. Antispasmodic (ex. Dicyclomine)
    c. Bile acid sequestrant (cholestyramine, colestipol or colesevelem)
    d. Tricyclic antidepressant (ex. nortriptyline)

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 09/2019

Last reviewed 09/2019

PriorityHealth

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)
Dose:_____ Dates: _____
Outcome:_____

☐ A bile acid sequestrant (ex: cholestyramine, colestipol or colesevelem)
Dose:_____ Dates: _____
Outcome:_____

☐ Dietary Changes
Dose:_____ 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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