AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization

Eluxadoline (Viberzi™)

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
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 is 18 years of age or older.
2. Patient has a diagnosis of irritable bowel syndrome with diarrhea (IBS-D).
3. Patient does not have any of the following contraindications to therapy:
   - 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.
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).
   - 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:
   - Improvement in abdominal cramping or pain.
   - 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

Dosage Instructions:

Strength: Quantity: Days Supply:

Diagnosis:

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Treatment failures:

Antispasmodic Trial (dicyclomine or hyoscyamine):

Name/Dose: Trial dates:

Failure reason:

Antidiarrheal Trial (loperamide):

Dose: Trial dates:

Failure reason:

Indicate if patient has any of the following contraindications to therapy:

Known or suspected biliary duct obstruction, or sphincter of Oddi disease/dysfunction:	☐ Yes ☐ No
Alcoholism, alcohol abuse, alcohol addiction, or consumption of more than 3 alcoholic beverages per day:	☐ Yes ☐ No
A history of pancreatitis or structural diseases of the pancreas (including known or suspected pancreatic duct obstruction):	☐ Yes ☐ No
Severe hepatic impairment (Child-Pugh Class C):	☐ Yes ☐ No
Severe constipation or sequelae from constipation:	☐ Yes ☐ No
Known or suspected mechanical gastrointestinal obstruction:	☐ Yes ☐ No

Renewal Requests

Has patient developed any contraindications to therapy (defined above)?	☐ Yes ☐ No

If 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.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further acknowledge that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
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.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.