Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Viberzi (eluxadoline) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Viberzi (eluxadoline).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Prescriber is a Gastroenterologist,
   □ No □ Yes

2. **AND** member has a diagnosis of irritable bowel syndrome (IBS-constipation predominant)

   □ No □ Yes

3. **AND** member has had an inadequate response (must try for the minimum duration listed before considered treatment failure); intolerance or contraindication to two of the following medications/medication classes (if ≥65 years old, trial of one of the following therapies is adequate):
   - Antidiarrheal agents (e.g., loperamide, diphenoxylate/atropine*) – 2 weeks' trial
   - Bile acid sequestrants (e.g., cholestyramine, colestipol, colesevelam) – at least 2 weeks' trial
   - Antispasmodics* (e.g., dicyclomine, diphenoxylate/atropine, chlordiazepoxide/clidinium, or hyoscyamine) – at least 2 weeks' trial
   - Tricyclic antidepressants* (e.g., amitriptyline, desipramine, imipramine) – at least 6 weeks' trial

   □ No □ Yes

4. **AND** patient has had an inadequate response (at least 4 weeks' trial), intolerance, or contraindication to Xifaxan (rifaximin) – also criteria-based

   □ No □ Yes

*Beer's Criteria; NOT recommended if ≥65 years old

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Member has a positive clinical response to Viberzi

   □ No □ Yes

7 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**