Prior Authorization Request Form for
Eluxadoline (Viberzi)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1

Please complete patient and physician information (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2

Please complete the clinical assessment:

1. Does the patient have a documented diagnosis of irritable bowel syndrome with diarrhea (IBS-D)?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is this request for renewal of therapy?	☐ Yes **SKIP** to question **14**	☐ No Proceed to question **3**
3. Is the initial prescription written by, or in consultation with, a gastroenterologist?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the patient greater than, or equal to, 18 years of age?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient drink alcohol?	☐ Yes Proceed to question **6**	☐ No Proceed to question **7**
6. Does the patient drink LESS THAN OR EQUAL TO 3 alcoholic beverages per day?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
7. Does the patient have a history of alcoholism, alcohol abuse, or alcohol addiction?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **8**

Continue to next page

8. Does the patient have a history of marijuana use or illicit drug use in the previous 6 months?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **9**
9. Does the patient have a severe hepatic impairment (Child-Pugh C)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. Has the patient tried and failed dietary changes (including fiber), stress reduction, or cognitive behavioral therapy?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Does the patient have a history of cholecystectomy?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Has the patient experienced failure, intolerance, or contraindication to AT LEAST ONE antispasmodic/ antidiarrheal agent: for example dicyclomine (Bentyl), Librax, hyoscyamine (Levsin), Donnatal, loperamide (Imodium)?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Has the patient experienced failure, intolerance, or contraindication to AT LEAST ONE tricyclic antidepressant to relieve abdominal pain: for example, amitriptyline, desipramine, doxepin, imipramine, nortriptyline, protriptyline?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
14. Has the patient had documented improvement in IBS-D symptoms?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____

[15 May 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: