US Family Health Plan
Prior Authorization Request Form for
Eluxadoline (Viberzi)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Initial approval expires after 4 months, renewal approval expires after 1 year.

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. Has the patient received this medication under the USFHP benefit in the last 6 months? *Please choose "No" if the patient did not previously have a USFHP approved PA for Viberzi.*	☐ Yes Proceed 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 use disorder, or alcohol addiction?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **8**

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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 _____

[30 July 2021]