



TEXAS MEDICAID Clinical Edit Prior Authorization eluxadoline (VIBERZI)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING

Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: MEDICATION INFORMATION

Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:
Patient's Primary Diagnosis: _____ ICD 10 Code: _____	

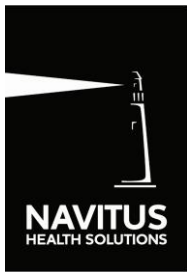
Please indicate ONE (1) of the following:

STAR / STAR KIDS client (**Go to Step 3 - PDL PA Criteria Applies**)

OR CHIP / PERINATE client (**Go to Step 4**)

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent (including gastrointestinal (GI) motility over the counter (OTC) products) in the last 180 days?
 Yes (Go to Step 4 Question 1) No (Go to #2)
2. Is there a documented allergy or contraindication to preferred agents in this class?
 Yes (Go to Step 4 Question 1) No (Go to #3)
3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?
 Yes (Go to Step 4 Question 1) No (Deny)



STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the client greater than or equal to (\geq) 18 years of age?

Yes (Go to #2)

No (Deny)

2. Does the client have a diagnosis of irritable bowel syndrome with diarrhea (IBS-D) in the last 730 days?

Yes (Go to #3)

No (Deny)

3. Does the client have a diagnosis of biliary duct obstruction or sphincter of Oddi disease in the last 365 days?

Yes (Deny)

No (Go to #4)

4. Does the client have a diagnosis of alcohol abuse or alcohol dependence in the last 365 days?

Yes (Deny)

No (Go to #5)

5. Does the client have a diagnosis of pancreatitis in the last 365 days?

Yes (Deny)

No (Go to #6)

6. Does the client have a history of a gastrointestinal (GI) obstruction in the last 365 days?

Yes (Deny)

No (Go to #7)

7. Is the quantity being requested less than or equal to (\leq) 2 tablets per day?

Yes (Approve – 365 days)

No (Deny)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: 855-668-8553

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.