



Fax completed form to Navitus at: 855-668-8553  
For questions, please call: 877-908-6023

### TEXAS MEDICAID

### Drug Prior Authorization

### Gastrointestinal (GI) Motility Agents: eluxadoline (VIBERZI)

#### Request Information (required)

This request is:

- Expedited\* (Urgent)
- Standard (Non-Urgent)

\*Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

#### Member Information (required)

#### Prescriber Information (required)

Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :		Specialty:
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

#### Please fill out the following information:

- Medication Requested (Name):  
(Go to #2)

Drug Prior Authorization

Gastrointestinal (GI) Motility Agents: eluxadoline (VIBERZI)

2. Quantity Requested:  
(Go to #3)

3. Dose Requested (Strength):  
(Go to #4)

4. Dosing Instructions:  
(Go to #5)

**Required Criteria**

5. Provide primary diagnosis including ICD-10 code(s):  
(Go to #6)

6. Please indicate the requested drug's formulary status: \*(Formulary available at [www.txvendordrug.com](http://www.txvendordrug.com))

Non-Preferred Drug (NPD or NAP)

(Go to #7)

Preferred Drug (PDL)

(Go to #10)

No Status, Drug is not in a Market Basket

(Go to #10)

N/A as this request is for a CHIP/PERINATE member

(Go to #10)

Preferred Drug List (PDL) Criteria (required for non-preferred products)

7. Has the member failed a 30-day treatment trial with at least one (1) preferred agent [including gastrointestinal (GI) motility over-the-counter (OTC) products] in the last 180 days?

Yes

(Go to #10)

No

(Go to #8)

8. Is there a documented allergy or contraindication to preferred agents in this class?

Yes

(Go to #10)

No

(Go to #9)

9. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

Yes

(Go to #10)

No (Deny)

(Go to #10)

Clinical Criteria (required)

10. Is the member greater than or equal to ( $\geq$ ) 18 years of age?

Yes

(Go to #11)

No (Deny)

(Go to #11)

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

Yes

(Go to #12)

No (Deny)

(Go to #12)

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

Yes (Deny)

(Go to #13)

No

(Go to #13)

13. Does the member have a diagnosis of alcohol abuse or addiction in the last 365 days?

Yes (Deny)

(Go to #14)

No

(Go to #14)

14. Does the member have a diagnosis of pancreatitis in the last 365 days?

Yes (Deny)

(Go to #15)

No

(Go to #15)

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

Yes (Deny)  
(Go to #16)

No  
(Go to #16)

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

Yes (Approve - 365 days)  
(Go to #17)

No (Deny)  
(Go to #17)

Additional Information

17. Please provide any additional information we should consider (or attach any supporting documents):  
(END)

**Submission Information (required)**

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\* PLEASE FAX COMPLETED FORM TO: 855-668-8553 \*\***

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If criteria not met, submit chart documentation with form citing complex medical circumstances.

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