Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Viberzi (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Florida at **1-855-799-2554**.
When conditions are met, we will authorize the coverage of Viberzi (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Viberzi (eluxadoline)

Other, specify drug ______________________________

Quantity __________ Frequency ______________ Strength __________

Route of administration __________ Expected length of therapy ______________

Patient information

Patient name: ______________________________

Patient ID: ______________________________

Patient Group No.: ______________________________

Patient DOB: ______________________________

Patient phone: ______________________________

Prescribing physician

Physician name: ______________________________

Specialty: ______________________ NPI number: ______________________

Physician fax: ______________________ Physician phone: ______________________

Physician address: ______________________ City, state, zip: ______________________

Diagnosis:______________________ **ICD Code:**______________________

Circle the appropriate answer for each question.

1. Is the patient 18 years of age or older? Y N

   [If no then no further questions.]

2. Does the patient have a diagnosis of Irritable Bowel Syndrome (IBS) with diarrhea as the predominant symptom, confirmed with colonoscopic examination within the previous 2 years? Y N

   [Note: Documentation required. A copy of the colonoscopy results should be submitted or addressed in the prescriber progress notes.
   ______________________________]

3. Has the patient had a documented trial of THREE of the following treatment options: A) Lifestyle and dietary modifications (elimination of caffeine, lactose or fructose from diet and/or addition of fiber to diet and/or use of probiotics), B) antidiarrheals (e.g. loperamide, cholestyramine), C) Antispasmodics (e.g. dicyclomine, hyoscyamine), D) tricyclic antidepressants (e.g. desipramine, amitriptyline, doxepin)? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**