BlueCross BlueShield Federal Employee Program

VIBERZI
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Viberzi (eluxadoline)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

Will the patient need more than 180 capsules every 90 days? ❑Yes* ❑No

If YES, please specify the requested quantity: _____ capsules every 90 days

1. Does the patient have a diagnosis of irritable bowel syndrome with diarrhea? ❑Yes ❑No
2. Does the patient have a biliary duct obstruction or sphincter of Oddi disease? ❑Yes ❑No
3. Does the patient have a diagnosis of alcoholism or does the patient drink more than 3 alcoholic beverages per day? ❑Yes ❑No
4. Does the patient have severe hepatic impairment (Child-Pugh Class C)? ❑Yes ❑No
5. Does the patient have gastrointestinal obstruction? ❑Yes ❑No
6. Does the patient have severe constipation? ❑Yes ❑No
7. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following question:

a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to **TWO** anti-diarrheal medications? ❑Yes ❑No

b. Does the patient have a history of pancreatitis or structural diseases of the pancreas including known or suspected pancreatic duct obstruction? ❑Yes ❑No

c. Does the patient have an average daily stool consistency score using the *Bristol Stool Scale (BSS) of Type 5 or greater? ❑Yes ❑No

***BSS:* https://www.bladderandbowel.org/help-information/resources/bristol-stool-form-scale/**

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

a. Has the patient had a reduction in their stool consistency score Bristol Stool Scale (BSS)? ❑Yes ❑No

b. Does the patient have pancreatic duct obstruction? ❑Yes ❑No