



PRIOR AUTHORIZATION REQUEST FORM
IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D)
 alosetron hydrochloride, Viberzi®, Xifaxan®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: alosetron hydrochloride, Viberzi® (eluxadoline), Xifaxan® (rifaximin)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is this request for an expedited review? By checking the “Yes” box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member been diagnosed with irritable bowel syndrome with diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the requesting provider a gastroenterologist?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Has the member had a trial and failure of nutritional and/or behavioral therapy (e.g. lactose restriction, gluten-free, low carb, increased physical activity, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Has the member had a trial and failure of, or contraindication to, at least one antidiarrheal (e.g. loperamide, diphenoxylate)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Has the member had a trial and failure of, or contraindication to, at least one antispasmodic (e.g. dicyclomine, hyoscyamine)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
7. Has the member had a trial and failure of, or contraindication to, at least one tricyclic antidepressant (e.g. imipramine, desipramine)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

8. For Viberzi®, does the member have any of the following: <ul style="list-style-type: none"> • No gallbladder • Known or suspected biliary duct obstruction or sphincter of Oddi disease/dysfunction • Alcoholism, alcohol abuse, or >3 alcoholic beverages/day • History of pancreatitis or structural disease of the pancreas • Severe hepatic impairment • Severe constipation or sequelae from constipation 	<input type="checkbox"/>	<input type="checkbox"/>	
9. For alosetron hydrochloride: Does the member have any of the following: <ul style="list-style-type: none"> • History of chronic or severe constipation • History of intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation and/or adhesions • History of ischemic colitis, impaired intestinal circulation, ulcerative colitis, or Crohn’s disease • Active diverticulitis or a history of diverticulitis • Concomitant use of fluvoxamine 	<input type="checkbox"/>	<input type="checkbox"/>	
REAUTHORIZATION			
1. Is the request for reauthorization?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does updated clinical documentation show continued medical necessity and disease stabilization or improvement of disease?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Please note: rifampin will only be approved for a maximum of three 14-day courses.	<input type="checkbox"/>	<input type="checkbox"/>	
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician’s Signature:			

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Policy: PHARM- 034
 Origination Date: 03/16/2018
 Reviewed/Revised Date: 05/22/2024
 Next Review Date: 05/22/2025
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