OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed.**

Drug Requested: (select drug below)

❑ **alosetron** (Lotronex®)	❑ **Viberzi®** (eluxadoline)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

❑ **Quantity Limit:**

- **For Lotronex (alosetron)** - Oral: Initial: 0.5 mg twice daily for 4 week; if tolerated, but response is inadequate, may be increased after 4 weeks to 1 mg twice daily (maximum dose: 2 mg/day). If response is inadequate after 4 weeks of 1 mg twice-daily dosing, discontinue treatment.
- **For Viberzi (eluxadoline)** - Oral: 100 mg twice daily; may decrease to 75 mg twice daily in patients unable to tolerate the 100 mg dose.

CLINICAL CRITERIA/DIAGNOSIS: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied. Check box below for the Diagnosis that applies.

Initial Approval - 6 months

❑ Member is 18 years of age or older

AND

❑ Diagnosis of irritable bowel syndrome with diarrhea (IBS-D) with chronic symptoms of IBS that have persisted for 6 months or longer **(please submit chart notes to confirm diagnosis)**

AND

❑ Member does NOT have constipation, history of chronic or severe constipation, or complications resulting from constipation

AND

❑ History of failure, contraindication or intolerance to **THREE** of the following **(verified by pharmacy paid claims as appropriate; please submit chart notes to confirm treatment failure or intolerance)**

- ❑ Antispasmodic agent (e.g. dicyclomine)
- ❑ Antidiarrheal agent (e.g. diphenoxylate/atropine)
- ❑ Tricyclic antidepressant (e.g. amitriptyline)
- ❑ Dietary Changes (e.g. low FODMAP diet, fiber supplementation, gluten-free diet)

(Continued on next page)

Reauthorization Approval: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member has had a positive clinical response to therapy demonstrated by an improvement in abdominal cramping/pain or in stool frequency and consistency

Medication being provided by a Specialty Pharmacy - PropriumRx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee:** 11/18/2016
REVISED/UPDATED: 9/14/2021