| | |
|---|---|
| **Clinical Policy Title:** | Eluxadoline |
| **Policy Number:** | RxA.548 |
| **Drug(s) Applied:** | Viberzi® |
| **Original Policy Date:** | 03/06/2020 |
| **Last Review Date:** | 01/01/2024 |
| **Line of Business Policy Applies to:** | All lines of business (except Medicare) |

## Criteria

**I. Initial Approval Criteria**

**A. Irritable Bowel Syndrome with Diarrhea** (must meet all)**:**

1. Diagnosis of IBS-D;
2. Trial and failure of the following unless contraindicated or clinically significant adverse effects are experienced;
   i. Anti-diarrheal agent (e.g., loperamide);
   ii. antispasmodic (e.g., dicyclomine).

**Approval Duration**

**All Lines of Business (except Medicare):** 12 months

**II. Continued Therapy Approval**

**A. Irritable Bowel Syndrome with Diarrhea** (must meet all)**:**

1. Member is currently receiving medication, excluding manufacturer samples.

**Approval Duration**

**All Lines of Business (except Medicare):** 12 months

**References**


1. Weinberg DS, Smalley W, Heidelbaugh JJ, Shahnaz S. American Gastroenterological Association Institute guideline on the pharmacological management of irritable bowel syndrome. Gastroenterology. 2014; 147: 1146-1149. https://pubmed.ncbi.nlm.nih.gov/25224526/. Accessed December 5, 2023.


| Review/Revision History | Review/Revision Date | P&T Approval Date |
|---|---|---|
| Policy established. | 01/2020 | 03/06/2020 |
| Policy was reviewed:<br>1. Policy title table was updated.<br>2. Line of Business Policy Applies to was update to all lines of business.<br>3. Commercial approval duration was updated for initial and Continued approval criteria from length of benefit to 12 months.<br>4. Continued therapy criteria II.A.1 was | 08/2020 | 12/07/2020 |

| | | |
|---|---|---|
| rephrased to “Currently receiving medication that has been authorized by RxAdvance…”.<br>5. References was reviewed and updated. | | |
| Policy was reviewed:<br>1. Continued Therapy Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...".<br>2. References were reviewed and updated. | 09/24/2021 | 12/07/2021 |
| Policy was reviewed:<br>1. Initial Approval Criteria I.A.3 and I.A.4: Updated to remove phrase maximally indicated dose.<br>2. References were reviewed and updated. | 09/19/2022 | 10/19/2022 |
| Policy was reviewed:<br>1. Removed prior age criteria.<br>2. Removed prior dosing criteria.<br>3. Updated approval duration.<br>4. Removed reauthorization requirement for positive response to therapy.<br>5. References were reviewed and updated. | 12/5/2023 | 01/01/2024 |