Clinical Policy: Eluxadoline (Viberzi)

Reference Number: NH.PMN.170
Effective Date: 10.26
Last Review Date: 10.26
Line of Business: Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Eluxadoline (Viberzi®) is a mu-opioid receptor agonist.

FDA Approved Indication(s)

Viberzi is indicated in adults for the treatment of irritable bowel syndrome with diarrhea (IBS-D).

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Viberzi is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Diagnosis of IBS-D;
2. Age ≥ 18 years;
3. Failure of an anti-diarrheal agent (e.g., loperamide) at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;
4. Trial and failure of two (2) preferred agents unless contraindicated or clinically significant adverse effects are experienced;
5. Failure of an antispasmodic (e.g., dicyclomine) at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;
6. Dose does not exceed both of the following (a and b):
   a. 200 mg per day;
   b. 2 tablets per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the PDL, the no coverage criteria policy CP.PMN.255; or
   b. For drugs NOT on the PDL, the non-formulary policy CP.PMN.16; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy: CP.PMN.53.

II. Continued Therapy

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

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed both of the following (a and b):
   a. 200 mg per day;
   b. 2 tablets per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the PDL, the no coverage criteria policy: CP.PMN.255; or
   b. For drugs NOT on the PDL, the non-formulary policy: CP.PMN.16; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy: CP.PMN.53.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
IBS-D: irritable bowel syndrome with diarrhea

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
loperamide (Imodium A-D®)	Adults: 4 mg PO followed by 2 mg after each unformed stool until diarrhea is resolved; then individualize dose. Administer optimal daily dose (4-8 mg) as single or divided doses.	If no clinical improvement after treatment with 16 mg/day for at least 10 days, symptoms are unlikely to be controlled by further use.
diphenoxylate/atropine (Lomotil®)	Initially, 5 mg (2 tablets) PO QID; Discontinue after 10 days if clinical improvement is not observed	20 mg/day (of diphenoxylate)
dicyclomine (Bentyl®)	Adults: 20 mg PO QID up to 1 week, then increase to 40 mg PO QID	160 mg/day (40 mg PO QID)
hyoscyamine (Levsin®, Levbid®)	Adults: Levsin: 0.125 – 0.25 mg PO Q 4h Levbid: 0.375 – 0.75 mg PO Q 12h	1.5 mg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Patients without a gallbladder
  - Known or suspected biliary duct obstruction; or sphincter of Oddi disease or dysfunction
  - Alcoholism, alcohol abuse or alcohol addiction, or in patients who drink more than 3 alcoholic beverages per day
  - A history of pancreatitis; or structural diseases of the pancreas, including known or suspected pancreatic duct obstruction
  - Known hypersensitivity reaction to Viberzi
  - Severe hepatic impairment (Child-Pugh Class C)
  - History of chronic or severe constipation or sequelae from constipation, or known or suspected mechanical gastrointestinal obstruction
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
IBS-D	100 mg PO BID OR 75 mg PO BID in patients who: • Are unable to tolerate the 100 mg dose of Viberzi • Are receiving concomitant OATP1B1 inhibitors • Have mild (Child-Pugh Class A) or moderate (Child-Pugh Class B) hepatic impairment	200 mg/day

Indication	Dosing Regimen	Maximum Dose
	• Have moderate or severe renal impairment (eGFR less than 60 mL/min/1.73m^2; and in patients with end stage renal disease (eGFR less than 15 mL/min/1.73m^2 not yet on dialysis	

VI. Product Availability

Tablets: 75 mg, 100 mg

VII. References

1. Viberzi Prescribing Information. Madison, NJ: Allergan; July 2024. Available at: https://www.viberzi.com/. Accessed July 10, 2026.
2. Weinberg DS, Smalley W, Heidelbaugh JJ, Shahnaz S. American Gastroenterological Association Institute guideline on the pharmacological management of irritable bowel syndrome. *Gastroenterology*. 2014; 147(5): 1146-1149. Available at: https://www.gastrojournal.org/article/S0016-5085(14)01089-0/pdf.
3. Lembo A, Sutan S, Chang L, et al. AGA clinical practice guideline on the pharmacological management of irritable bowel syndrome with diarrhea. Gastroenterology. 2022; 164: 137-151.
4. Lacy BE, Pimentel M, Brenner DM. ACG clinical guideline: Management of irritable bowel syndrome. American Journal of Gastroenterology. 2021; 116(1): 17-44.
5. Clinical Pharmacology [database online]. Philadelphia, PA: Elsevier; 2020. Available at: http://www.clinicalkey.com/pharmacology.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	10.26	10.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and

limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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