UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2023 P 2030-14
Program	Prior Authorization/Medical Necessity
Medication	Xifaxan (rifaximin)
P&T Approval Date	8/2014, 7/2015, 10/2015, 10/2016, 10/2017, 4/2018, 4/2019, 4/2020, 4/2021, 04/2022, 7/2022, 7/2023
Effective Date	10/1/2023; Oxford only: 10/1/2023

1. Background:

Xifaxan is an antibacterial agent indicated for the treatment of travelers' diarrhea caused by noninvasive strains of *Escherichia coli* in patients 12 years of age and older, for the risk reduction of hepatic encephalopathy recurrence in adults and for the treatment of irritable bowel syndrome with diarrhea (IBS-D). There is limited data to support the off label use of Xifaxan for the treatment of inflammatory bowel disease.

This program requires a member to try an alternative antimicrobial agent before providing coverage for Xifaxan for traveler's diarrhea and for inflammatory bowel disease, lactulose before providing coverage for Xifaxan as add-on therapy for hepatic encephalopathy, or a tricyclic antidepressant or Viberzi (eluxadoline) before providing coverage for Xifaxan for IBS-D. Members utilizing Xifaxan 200 mg for Travelers' Diarrhea will automatically be approved if prescribed for a one-time dose of 9 tablets.

2. Coverage Criteria[a]:

A. Travelers' Diarrhea

1. **Authorization**

a. **Xifaxan** will be approved based on both of the following criteria:

(1) Travelers' diarrhea

-AND-

(2) History of failure, contraindication or intolerance to **one** of the following:

(a) Azithromycin (generic Zithromax)
(b) Ciprofloxacin (generic Cipro)
(c) Levofloxacin (generic Levaquin)
(d) Ofloxacin (generic Floxin)

Authorization will be issued for one month

B. Hepatic Encephalopathy

1. **Initial Authorization**

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a. **Xifaxan** will be approved based on **both** of the following criteria:

(1) Hepatic Encephalopathy

-AND-

(2) **One** of the following

(a) **Both** of the following:

i. Used as add-on therapy to lactulose

-AND-

ii Patient is unable to achieve an optimal clinical response with lactulose monotherapy

-OR-

(b) History of contraindication or intolerance to lactulose

Authorization will be issued for 12 months

2. **Reauthorization**

a. **Xifaxan** will be approved based on the following criterion:

(1) Documentation of positive clinical response to Xifaxan therapy

Authorization will be issued for 12 months

C. Irritable Bowel Syndrome with diarrhea (IBS-D)

1. **Initial Authorization**

a. **Xifaxan** will be approved based on **all** of the following criteria:

(1) Diagnosis of IBS-D

-AND-

(2) History of failure, contraindication or intolerance to a tricyclic antidepressant (e.g. amitriptyline)

-AND-

(3) One of the following:

a) History of failure, contraindication or intolerance to Viberzi

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-OR-

b) History of or potential for a substance abuse disorder

Authorization will be issued for 14 days

2. **Reauthorization**

a. **Xifaxan** will be approved based on **all** of the following criteria:

(1) Patient has experienced a recurrence of IBS-D after a prior 14 day course of therapy with Xifaxan
(2) Patient has had a treatment-free period between courses of therapy
(3) Patient has not already received 3 treatment courses of Xifaxan for IBS-D in the previous 6 months

Authorization will be issued for 14 days

D. Inflammatory Bowel Disease (e.g. Crohn's Disease, Ulcerative Colitis, Diverticulitis) (Off Label)

1. **Initial Authorization**

a. **Xifaxan** will be approved based on **both** of the following criteria:

(1) Diagnosis of Inflammatory Bowel Disease

-AND-

(2) History of failure, contraindication or intolerance to **both** of the following:

(a) Ciprofloxacin (generic Cipro)
(b) Metronidazole (generic Flagyl)

Authorization will be issued for 12 months

2. **Reauthorization**

a. **Xifaxan** will be approved based on the following criterion:

(1) Documentation of positive clinical response to Xifaxan therapy

Authorization will be issued for 12 months

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

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3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may apply

4. References:

1. Xifaxan [package insert]. Bridgewater, NJ: Bausch Health US, LLC; September 2022.
2. Prantera C, et. Al. Antibiotic treatment of Crohn's disease: results of a multicenter, double blind, randomized, placebo-controlled trial with rifaximin. Aliment Pharmacol Ther 2006 April 15;23(8): 1117-25
3. Scherl EJ. Bacteria, bugs and BID rifaximin for Crohn's disease. Inflamm Bowel Dis 2007 June;13(6):800-1.
4. LaRocque, R. Travelers's diarrhea: Treatment and prevention. In:UpToDate, Calderwood, SB (Ed), UpToDate. Waltham, MA. (Accessed on May 2023).
5. Pimentel H, Lembo A, Chey W, et al: Rifaximin therapy for patients with Irritable Bowel Syndrome without constipation. N Engl J Med 2011; 364(1):22-32
6. Lacey, BE, Pimentel, M, Brenner, DM, et. al. ACG Clinical Guideline: Management of Irritable Bowel Syndrome. Am J Gastroenterol. 2021; 116 (1): 17-44.
7. American Gastroenterological Association Institute Guideline on the Pharmacological Management of Irritable Bowel Syndrome. 2014.
8. Vilstrup H, Amodio P, Bajaj J, et al. Hepatic encephalopathy in chronic liver disease: 2014 Practice Guideline by the American Association for the Study of Liver Diseases and the European Association for the Study of the Liver. Hepatology. 2014;60:715-735.
9. ACG Clinical Guideline: Small Intestinal Bacterial Overgrowth. *Am J Gastroenterol. 2020; 115: 165-78.*

Program	Prior Authorization/Medical Necessity – Xifaxin
Change Control	
Date	Change
8/2014	New program.
9/2014	Administrative change - Tried/Failed exemption for State of New Jersey removed.
7/2015	Annual Review. Added irritable bowel syndrome with diarrhea (IBS-D)
10/2015	Updated Step 1 agents for IBS-D. Updated references.
7/2016	Added Indiana and West Virginia coverage information.
10/2016	Updated Step 1 agents for IBS-D. Updated references.
11/2016	Added California coverage information.
10/2017	Annual review. Updated background and state mandate information. References updated.
4/2018	Updated criteria for hepatic encephalopathy. Updated references.
8/2018	Administrative update due to correct typo.
4/2019	Annual review. Added statement regarding use of automated processes and updated references.
4/2020	Annual review. Updated references.
4/2021	Annual review. Removed antispasmodic and antidiarrheal agent as a step 1 option for IBS-D based on updated ACG guidelines. Added

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	reauthorization for hepatic encephalopathy. Updated references.
4/2022	Annual review. No changes.
7/2022	Added step requirement of Viberzi for IBS-D.
7/2023	Annual review. Updated references.

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