Antibiotics: Anti-Infective Agents – Oral
rifaximin (Xifaxan®)

Medical policy no. 16.00.00.49  Effective Date: July 1, 2019

Background:
Rifaximin is a non-absorbable antibiotic that is used for gastrointestinal infections and other conditions involving the gastrointestinal system. Gastrointestinal infections are viral, bacterial, or parasitic infections that cause gastroenteritis, an inflammation of the gastrointestinal tract involving both the stomach and the small intestine. Symptoms include diarrhea, vomiting, and abdominal pain. Rifaximin is utilized in the treatment of bacterial gastrointestinal infections. Rifaximin can also be used for the prophylaxis of hepatic encephalopathy when used together with lactulose.

Medical necessity

<table>
<thead>
<tr>
<th>Drug</th>
<th>Medical Necessity</th>
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<tbody>
<tr>
<td>rifaximin (Xifaxan®)</td>
<td>Rifaximin for gastrointestinal conditions may be considered medically necessary when used for:</td>
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<tr>
<td></td>
<td>• Prophylaxis of hepatic encephalopathy</td>
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<tr>
<td></td>
<td>• Treatment of irritable bowel syndrome with diarrhea (IBS-D)</td>
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<tr>
<td></td>
<td>• Treatment of traveler’s diarrhea caused by noninvasive strains of E. coli</td>
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Clinical policy:

<table>
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<tr>
<th>Indication</th>
<th>Clinical Criteria (Initial Approval)</th>
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| Prophylaxis of hepatic encephalopathy | 1. Patient has a history of overt hepatic encephalopathy OR liver cirrhosis;  
|                                    | 2. Patient has ONE of the following:  
|                                    |   a. Currently stabilized on and will continue to use lactulose at maximally tolerated dose; OR  
|                                    |   b. History of failure of lactulose at a maximally tolerated dose for at least 30 days, or contraindication or intolerance to lactulose; AND  
|                                    | 3. Patient is greater than or equal to 18 years of age; AND  
|                                    | 4. Dose less than or equal to 1,100mg per day; AND  
|                                    | 5. Baseline documentation of serum ammonia  
|                                   | If ALL criteria are met, the request will be approved for 12 months |
| Criteria (Reauthorization)        | 1. Most recent lab value(s) of serum ammonia; AND  
|                                   | 2. Documentation of an improvement in hepatic encephalopathy, such as any ONE of the following: |
Irritable bowel syndrome with diarrhea (IBS-D)

Clinical Criteria (Initial Approval)
1. Patient has a history of failure, contraindication or intolerance to **TWO** prior therapies for the treatment of IBS-D:
   a. antidiarrheal (e.g., loperamide); **OR**
   b. antispasmodics (e.g., dicyclomine); **OR**
   c. tricyclic antidepressants (e.g., amitriptyline); **AND**
2. Patient is greater than or equal to 18 years of age; **AND**
3. Dose less than or equal to 1,650mg per day for 14 days
4. Patient has not used more than 2 courses of treatment for IBS-D in lifetime

If ALL criteria are met, the request will be approved for a 14-day supply.

Criteria (Reauthorization)
1. Documentation of improvement in IBS-D related symptoms from previous course(s) of treatment; **AND**
2. Documentation with rationale for continued use of rifaximin; **AND**
3. Patient has not used more than 2 courses of treatment for IBS-D in lifetime

If ALL criteria are met, the request will be approved for up to 2 more 14-day supplies.

Infecous/traveler's diarrhea, noninvasive strains of E coli

Clinical Criteria (Initial Approval)
1. Confirm that this episode (infection) of traveler’s diarrhea is caused by non-invasive strains of **E. coli**
2. Patient has failed prior antibiotic treatment for this episode (defined as no improvement or resolution of symptoms after 5 days of completing regimen) or contraindication or intolerance to **TWO** of the following:
   a. Azithromycin; **OR**
   b. Ciprofloxacin; **OR**
   c. Levofloxacin; **AND**
3. Culture/sensitivity testing showing antibiotic resistance to all **THREE** of the following:
   a. Azithromycin; **OR**
   b. Ciprofloxacin; **OR**
   c. Levofloxacin; **AND**
4. Patient has not previously failed rifaximin for current episode or has culture/sensitivity testing showing antibiotic resistance to rifaximin; AND
5. Patient is greater than or equal to 12 years of age; AND
6. Dose is less than or equal to 600 mg per day for 3 days

If ALL criteria are met, the request will be approved for a 3-day supply.

Criteria (Reauthorization)
Requests for renewal or extension beyond the authorized amount for rifaximin for the same treatment episode will be denied as not medically necessary, except:
1. when all other treatment options have been ruled out; AND
2. culture/sensitivity testing shows no antibiotic resistance to rifaximin

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**Dosage and quantity limits**

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<thead>
<tr>
<th>Drug Name</th>
<th>Dose and Quantity Limits</th>
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<tbody>
<tr>
<td>rifaximin (XIFAXAN®) 200mg tablet</td>
<td>Infectious/traveler’s diarrhea: #9 tablet for 3-day treatment</td>
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<tr>
<td>rifaximin (XIFAXAN®) 550mg tablet</td>
<td>Hepatic encephalopathy: #60 tablets per 30-day supply</td>
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<td>IBS-D: #42 tablets per 14-day supply</td>
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**References**


History

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<thead>
<tr>
<th>Date</th>
<th>Action and Summary of Changes</th>
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<tr>
<td>05.31.2019</td>
<td><strong>Hepatic encephalopathy:</strong> Removed baseline documentation of predefined clinical criteria as specified by the provider</td>
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<tr>
<td>05.03.2019</td>
<td>New Policy</td>
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