

# PRIOR AUTHORIZATION CRITERIA

**BRAND NAME**  
(generic)

**XIFAXAN 550MG ONLY**  
(rifaximin)

**Status: CVS Caremark® Criteria**  
**Type: Initial Prior Authorization**

**Ref # 681-A**

## POLICY

### FDA-APPROVED INDICATIONS

#### Hepatic Encephalopathy

Xifaxan is indicated for reduction in risk of overt hepatic encephalopathy (HE) recurrence in adults.

In the trials of Xifaxan for HE, 91% of the patients were using lactulose concomitantly. Differences in the treatment effect of those patients not using lactulose concomitantly could not be assessed.

Xifaxan has not been studied in patients with MELD (Model for End-Stage Liver Disease) scores > 25, and only 8.6% of patients in the controlled trial had MELD scores over 19. There is increased systemic exposure in patients with more severe hepatic dysfunction.

#### Irritable Bowel Syndrome with Diarrhea

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

#### Compendial Uses

Small intestinal bacterial overgrowth (SIBO)<sup>3</sup>

### COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed to reduce the risk of overt hepatic encephalopathy (HE) recurrence  
**AND**

- The requested drug is being used as add-on therapy to lactulose

**OR**

- The requested drug is being prescribed for the treatment of irritable bowel syndrome with diarrhea (IBS-D)  
**AND**

- The patient has NOT previously received treatment with the requested drug for irritable bowel syndrome with diarrhea (IBS-D)

**OR**

- The patient has previously received treatment with the requested drug for irritable bowel syndrome with diarrhea (IBS-D)

**AND**

- The patient is experiencing a recurrence of symptoms

**AND**

- The patient has not already received an initial 14-day course of treatment AND two additional 14-day courses of treatment with the requested drug for the treatment of irritable bowel syndrome with diarrhea (IBS-D)

**OR**

- The requested drug is being prescribed for the treatment of small intestinal bacterial overgrowth (SIBO)  
**AND**

Xifaxan 550mg PA Policy 681-A UDR 04-2023 v2

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- The patient's diagnosis has been confirmed by ONE of the following: A) quantitative culture of upper gut aspirate, B) breath testing (e.g., lactulose hydrogen or glucose hydrogen breath test)

**OR**

- The patient is experiencing a recurrence of small intestinal bacterial overgrowth (SIBO) after completion of a successful course of the requested drug

Duration of Approval (DOA):

- 681-A:
  - Hepatic Encephalopathy (HE): DOA: 12 months
  - Irritable Bowel Syndrome with Diarrhea (IBS-D): DOA: 14 days
  - Small Intestinal Bacterial Overgrowth (SIBO): DOA: 14 days

**REFERENCES**

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