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 some limited data to support the off label use of Xifaxan for the treatment of inflammatory bowel diseases.

   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 an antispasmodic agent, an antidiarrheal agent and/or a tricyclic antidepressant 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. **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) Levofoxacin (generic Levaquin)
               (d) Ofloxacin (generic Floxin)

         **Authorization will be issued for one month**
B. Hepatic Encephalopathy

1. Authorization

   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

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

1. Initial Authorization

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

      (1) Diagnosis of IBS-D

      -AND-

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

         (a) antispasmodic agent [e.g. Bentyl (dicyclomine)]
         (b) antidiarrheal agent (e.g. loperamide)
         (c) tricyclic antidepressant (e.g. amitriptyline)

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 6 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.
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:**


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<tr>
<th>Program</th>
<th>Prior Authorization/Medical Necessity – Xifaxin</th>
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<tbody>
<tr>
<td>Date</td>
<td>Change Control</td>
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<tr>
<td>8/2014</td>
<td>Change</td>
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<tr>
<td>9/2014</td>
<td>New program.</td>
</tr>
<tr>
<td>7/2015</td>
<td>Annual Review. Added irritable bowel syndrome with diarrhea (IBS-D)</td>
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<tr>
<td>10/2015</td>
<td>Updated Step 1 agents for IBS-D. Updated references.</td>
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<tr>
<td>7/2016</td>
<td>Added Indiana and West Virginia coverage information.</td>
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<tr>
<td>10/2016</td>
<td>Updated Step 1 agents for IBS-D. Updated references.</td>
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<tr>
<td>11/2016</td>
<td>Added California coverage information.</td>
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<table>
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<tr>
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<tbody>
<tr>
<td>10/2017</td>
<td>Annual review. Updated background and state mandate information. References updated.</td>
</tr>
<tr>
<td>4/2018</td>
<td>Updated criteria for hepatic encephalopathy. Updated references.</td>
</tr>
<tr>
<td>8/2018</td>
<td>Administrative update due to correct typo.</td>
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