UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 2030-16
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, 7/2024, 7/2025
Effective Date	10/1/2025

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).

This program requires a member to try a lower cost alternative before providing coverage for Xifaxan. 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**

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

-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

[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:

1. Xifaxan [package insert]. Bridgewater, NJ: Bausch Health US, LLC; October 2023.
2. LaRocque, R. Travelers's diarrhea: Treatment and prevention. In:UpToDate, Calderwood, SB (Ed), UpToDate. Waltham, MA. April 2025
3. Lacey, BE, Pimentel, M, Brenner, DM, et. al. ACG Clinical Guideline: Management of Irritable Bowel Syndrome. Am J Gastroenterol. 2021; 116 (1): 17-44.
4. AGA Clinical Practice Guideline on the Pharmacological Management of Irritable Bowel Syndrome With Diarrhea. Gastroenterology. 2022.
5. 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.
6. 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 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.
7/2024	Annual review. Updated references.
7/2025	Annual review. Removed inflammatory bowel disease due to limited data available. Updated references.