Pharmacy Medical Necessity Guidelines: Xifaxan® (rifaximin)

Effective: April 1, 2020

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM

These pharmacy medical necessity guidelines apply to the following:

Commercial Products

☒ Tufts Health Plan Commercial products – large group plans
☒ Tufts Health Plan Commercial products – small group and individual plans
☒ Tufts Health Freedom Plan products – large group plans
☒ Tufts Health Freedom Plan products – small group plans
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Tufts Health Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan

Fax Numbers:
RXUM: 617.673.0988
MM: 888.415.9055
PRECERT: 617.972.9409

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS

Xifaxan (rifaximin) 200 mg tablets are indicated for the treatment of travelers' diarrhea caused by noninvasive strains of *Escherichia coli* in adults and pediatric patients 12 years of age and older.

Xifaxan (rifaximin) should not be used in patients with diarrhea complicated by fever or blood in the stool or diarrhea due to pathogens other than *E. coli*.

Xifaxan (rifaximin) 550 mg tablets are indicated for reduction in risk of overt hepatic encephalopathy recurrence in adults.

Xifaxan (rifaximin) 550 mg tablets are also indicated for the treatment of irritable bowel syndrome with diarrhea in adults.

COVERAGE GUIDELINES

The plan may authorize coverage of Xifaxan (rifaximin) for members when **all** the following criteria are met:

For Treatment of Traveler's Diarrhea

1. The member has a documented diagnosis of traveler's diarrhea caused by noninvasive strains of *Escherichia coli*

For Hepatic Encephalopathy

1. The member has a physician-documented diagnosis of hepatic encephalopathy

AND

2. The member has had an inadequate response or has a contraindication to lactulose (Constulose, Duphalac, Enulose, Generlac)

For Inflammatory Bowel Disease

1. The member has a documented diagnosis of Inflammatory Bowel Disease (IBD)

AND

2. The member has failed to respond to or has a contraindication to standard antibiotic treatment (e.g., ciprofloxacin [Cipro®], metronidazole [Flagyl®])

For Small Intestine Bacterial Overgrowth (SIBO)

1. The member has a documented diagnosis of small intestine bacterial overgrowth

AND

2. The prescribing physician is a gastroenterologist

AND

a. The member has failed to respond to at least two different classes of antibiotic treatment (e.g., ciprofloxacin, metronidazole, amoxicillin-clavulanate, trimethoprim-sulfamethoxazole)

OR

b. The member has contraindication to all these antibiotic treatments: ciprofloxacin, metronidazole, amoxicillin-clavulanate

For Irritable Bowel Syndrome with Diarrhea (IBS-D)

1. The member has a documented diagnosis of irritable bowel syndrome with diarrhea (IBS-D)

LIMITATIONS

- Xifaxan (rifaximin) would not be covered in the following instances:
  - Treatment of diarrhea caused by pathogens other than *E. coli*
  - Treatment of diarrhea complicated by fever or bloody stools
  - Treatment of Irritable Bowel Syndrome with constipation
  - Prevention of traveler's diarrhea
- For traveler's diarrhea, coverage is limited to a 3-day course of therapy (9 tablets) of the 200 mg tablets in any 30-day period.
- For Hepatic Encephalopathy, coverage is limited to 60 tablets per 30 days of the 550 mg tablets.
- For Irritable Bowel Syndrome with Diarrhea (IBS-D), coverage will be limited to 3 tablets of 550mg per day for one treatment cycle of 14 days. Subsequent authorizations will require clinical documentation of recurrence from the provider. Xifaxan (rifaximin) for the treatment of IBS-D will only be authorized up to a maximum of three treatment cycles.
- For Small Intestine Bacterial Overgrowth (SIBO), coverage is limited to 3 of the 550mg tablets per day for a 14 day treatment cycle. Coverage of Xifaxan for SIBO is limited to no more than two treatment cycles per life of plan. Subsequent treatment cycle requires reauthorization.
- Duration of coverage for other non-FDA-approved indications that have been deemed medically necessary will be determined based on the dosing and length of treatment recommended by compendia for the requested indication. Subsequent approvals for non-FDA-approved indications will be reviewed on a case by case basis.

CODES

None

REFERENCES

1. Lembo A, Pimentel M, Rao SS, et al., Repeat Treatment With Rifaximin Is Safe and Effective in Patients With Diarrhea-Predominant Irritable Bowel Syndrome. Gastroenterology. 2016;151(6):1113.
2. Loguercio C, Federico A, De Girolamo V, Ferrieri A, Del Vecchio Blanco C. Cyclic treatment of chronic hepatic encephalopathy with rifaximin. Results of a double-blind clinical study. Minerva Gastroenterol Dietol. 2003; 49(1):53-62.
3. Pimentel M et al. Rifaximin Therapy for Patients with Irritable Bowel Syndrome without Constipation. N Engl J Med 2011; 364: 22-32.
4. Ridola L, Zullo A, Hassan C, Saudi J. Rifaximin for treatment of hepatic encephalopathy: Some considerations.Gastroenterol. 2013; 19(1):56. doi: 10.4103/1319-3767.105930.
5. Sachdev A. H. and Pimentel M. Gastrointestinal bacterial overgrowth: pathogenesis and clinical significance. Ther Adv Chronic Dis. 2013 Sep; 4(5): 223–231. doi: 10.1177/2040622313496126
6. Xifaxan [Package insert]. Raleigh, NC: Salix Pharmaceuticals, Inc.; January 2018.

APPROVAL HISTORY

August 8, 2006: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. July 10, 2007: Added limitation "Pharmacy Coverage Guidelines for Xifaxan (rifaximin) apply to the Tufts Health Plan Generic Focused Formulary only."
2. September 11, 2007: Removed limitation "Pharmacy Coverage Guidelines for Xifaxan (rifaximin) apply to the Tufts Health Plan Generic Focused Formulary only." Added reference table outlining applicable Tufts Health Plan products.
3. July 8, 2008: Added coverage criteria for the diagnosis of hepatic encephalopathy. Added coverage criteria for the diagnosis of Inflammatory Bowel Disease (IBD). Added limitation, that Xifaxan will not be covered for the treatment of bacterial overgrowth. Removed limitation that Xifaxan would not be covered for the treatment of hepatic encephalopathy. Clarified limitation,

that Xifaxan coverage is limited to a 3-day course of therapy (9 tablets) in any 30-day period for traveler's diarrhea.
4. July 14, 2009: No changes
5. January 1, 2010: Removal of Tufts Health Plan Medicare Preferred language (separate criteria have been created specifically for Tufts Health Plan Medicare Preferred).
6. July 13, 2010: Removed, "Rifaximin tablets are indicated for the treatment of traveler's diarrhea caused by noninvasive strains of *E.coli* in adults and adolescents 12 years of age or older at a dose of 200 mg 3 times a daily for 3 days. Rifaximin was not found to be effective in patients with diarrhea complicated by fever or blood in the stool or diarrhea due to pathogens other than *E.coli*. Rifaximin is not effective and should not be used for the treatment of traveler's diarrhea caused by *Campylobacter jejuni* and has not been proven effective in traveler's diarrhea caused by *Shigella* spp. and *Salmonella* spp." Added FDA-approved indications for rifaximin 200 mg and 550 mg tablets. Removed, "The member must be 12 years of age or older" for Traveller's diarrhea indication. Under Hepatic Encephalopthy: Removed, "The member has failed to respond to or has a contraindication to lactulose (Constulose, Duphalac, Enulose, Generlac); replaced with "The member has had an inadequate response or contraindication to lactulose (Constulose, Duphalac, Enulose, Generlac). Clarified the limitation for Travelers diarrhea that it applies to the 200 mg strength. Added a limitation for Hepatic encephalopathy that "coverage is limited to a 30-day supply (60 tablets) of the 550 mg tablets
7. May 10, 2011: Removed the overview section and replaced with FDA-approved indications. Removed the limitation on Bacterial Overgrowth Syndrome. Added limitation of Irritable Bowel Syndrome.
8. March 13, 2012: No changes
9. February 12, 2013: No changes
10. February 11, 2014: No changes
11. February 10, 2015: No changes
12. October 6, 2015: Added criteria and limitations for new indication to treat irritable bowel syndrome with diarrhea.
13. January 1, 2016: Administrative change to rebranded template.
14. September 13, 2016: Added limitation #5 to clarify the duration of approval for off-label use: "Duration of coverage for non-FDA-approved indications that have been deemed medically necessary will be determined based on the dosing and length of treatment recommended by compendia for the requested indication. Subsequent approvals for non-FDA-approved indications will be reviewed on a case by case basis."
15. April 11, 2017: Administrative update, Adding Tufts Health RITogether to the template.
16. September 12, 2017: Administrative update- minor editing of the overview section.
17. December 11, 2018: Administrative update to the template.
18. December 10, 2019: Added coverage criteria, limitation, and reference for Small Intestine Bacterial Overgrowth.
19. February 11, 2020: Updated the limitation section to clarify the quantity limitation for the treatment of IBS-D is 42 tablets for a 14 day treatment cycle.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.