TITLE: RIFAXIMIN (XIFAXAN®) 550mg

EFFECTIVE DATE: May 1, 2015

DOCUMENT HISTORY
Original Endorsement Date: 11/29/12
Subsequent Endorsement Date(s): 1/30/14; 2/5/15

This policy was developed and approved by the Medica Pharmacy and Therapeutics Committee.

Important Information – Please Read Before Using This Policy

These services may or may not be covered by all Medica plans. Please refer to the member’s plan document for specific coverage information. If there is a difference between this general information and the member’s plan document, the member’s plan document will be used to determine coverage. With respect to Medicare, Medicaid and Minnesotacare members, this policy will apply unless these programs require different coverage. Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Medica coverage policy may call the Medica Provider Service Center toll-free at 1-800-458-5512.

Medica utilization management policies are not medical advice. Members should consult with appropriate healthcare providers to obtain needed medical advice, care and treatment.

PURPOSE
To promote consistency between reviewers in utilization management decision-making by providing the criteria that generally determines the medical necessity of rifaximin (Xifaxan®) 550mg. The Coverage issues box below outlines the process for addressing the needs of individuals who do not meet these criteria.

MEDICAL NECESSITY CRITERIA

I. Xifaxan® 550mg is considered medically necessary for the following disease states:
   a. Reduction in risk of overt hepatic encephalopathy (HE) recurrence in patients ≥18 years of age
   b. Irritable bowel syndrome, Without Constipation (IBS-d or IBS-dia) [as defined by ROME II diagnosis criteria]
   c. Treatment of small intestinal bacterial overgrowth (SIBO) or bacterial overgrowth causing diarrhea

II. Written documentation from the medical record must include:
   a. Diagnosis of at least one of the medically necessary disease states listed in Section I
   b. Documentation of previously tried medicinal therapies
   c. Prescription written or recommended by a gastroenterologist

III. Written documentation from the medical record must include:
   a. For hepatic encephalopathy (HE)
      i. Trial of lactulose or neomycin; or contraindication (relative or absolute) to either agent
   b. For irritable bowel syndrome, Without Constipation (IBS-d or IBS-dia)
      Initial Criteria
      i. Trial of at least 2 other types of medications utilized in the treatment of IBS-d or IBS-dia
      Renewal Criteria
      i. Time lapse of at least 10 weeks since completion of the last course of rifaximin
   c. For small intestinal bacterial overgrowth (SIBO) or bacterial overgrowth causing diarrhea
      Initial Criteria
      i. Trial of at least 1 antibiotic
Renewal Criteria

i. Time lapse of at least 10 weeks since completion of the last course of rifaximin

COVERAGE ISSUES

1. Prior authorization is required.
2. Coverage may vary according to the terms of the member’s coverage document.
3. When submitting a request for clinical review, Medica must receive a completed General Prior Authorization Form. Complete all fields and fax the form to the MedImpact Prior Authorization Department at 1-858-790-7100 or call 1-800-788-2949.
4. If the Medical Necessity and Coverage Criteria are met, Medica will authorize benefits within the limits in the member’s coverage document.
5. If it appears that the Medical Necessity and Coverage Criteria are not met, the individual’s case will be reviewed by the medical director or an external reviewer. Practitioners are advised of the appeal process in their Medica administrative handbook.

References