Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
XIFAXAN (Rifaximin) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage **XIFAXAN (Rifaximin).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

Length of Authorization:

- Initial: 12 months for Hepatic Encephalopathy; Continuation: 6 months
- Irritable Bowel Syndrome with diarrhea-14 days (one-time)
- *C. difficile* associated diarrhea -1 month (one-time)
- Traveler's diarrhea-3 days (one-time)
- Small Intestinal Bacterial Overgrowth-14 days (2 treatment courses per year)

1 – Patient Information

Patient Name: ________________________________ Kaiser Medical ID#: __________________ Date of Birth: ______________

2 – Prescriber Information

Prescriber Name: ________________________________ Specialty: ______________________________ NPI: __________________

Prescriber Address: ____

Prescriber Phone #: ___________________________Prescriber Fax #: _____________________________

3 – Pharmacy Information

Pharmacy Name: __________________________________ Pharmacy NPI: ____

Pharmacy Phone #_________________________________ Pharmacy Fax #: ____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: ____

Sig: ____

Drug 2: Name/Strength/Formulation: ____

Sig: ____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State date: _________________________

2. Indicate the Member's diagnosis for the requested medication: ____

Clinical Criteria:

Prescribed by an Infectious Disease Specialist, a Gastroenterologist, or in consultation with a Gastroenterologist, **AND**
□ No □ Yes

Hepatic Encephalopathy:

1. Member has a diagnosis of hepatic encephalopathy,
   □ No □ Yes

2. **AND** member is ≥18 years of age**,**
   □ No □ Yes

3. **AND** Xifaxan (rifaximin) is being used as add-on therapy to lactulose,
   □ No □ Yes

4. **AND** member is unable to achieve an optimal response with lactulose monotherapy after receiving an adequate trial,
   □ No □ Yes

5. **OR** member is intolerant or has contraindications to lactulose
   □ No □ Yes

Irritable Bowel Syndrome with diarrhea:

1. Member has a diagnosis of irritable bowel syndrome diarrhea predominant (IBS-D)**,**
   □ No □ Yes

2. **AND** member has contraindication to, is intolerant to, or failed treatment with TWO of the following medications (must try for the minimum duration listed before considered treatment failure):
   a. Loperamide - at least 2 weeks
   b. Diphenoxylate-atropine (Lomotil) - at least 2 weeks
   c. A bile acid sequestrant (e.g., cholestyramine, colestipol) - at least 2 weeks
   d. Dicyclomine (generic Bentyl) - at least 2 weeks
   e. At least one tricyclic antidepressant - at least 6 weeks

   □ No □ Yes

3. **AND** member has not completed > 3 total treatments with rifaximin for IBS-D (maximum 3 treatments with rifaximin per patient)?
   □ No □ Yes

C. *difficile:*

1. Member has a diagnosis of third recurrence of *C. difficile* associated diarrhea
   □ No □ Yes

2. **AND** member has failed treatment with metronidazole and vancomycin for previous episodes
   □ No □ Yes

Traveler’s Diarrhea:

1. Member has a diagnosis of Traveler’s Diarrhea
   □ No □ Yes

2. **AND** member is intolerant or unable to take a fluoroquinolone
   □ No □ Yes

3. **AND** member is intolerant or allergic to azithromycin
   □ No □ Yes

Small Intestinal Bacterial Overgrowth (SIBO)

1. Member has a diagnosis of small intestinal bacterial overgrowth (SIBO),
   □ No □ Yes

2. **AND** member has documented failure of treatment with at least **ONE** of the following:
   a. Amoxicillin-clavulanate
   b. Ciprofloxacin
   c. Trimethoprim-sulfamethoxazole
   d. Metronidazole
   e. Doxycycline
   f. Tetracycline
   □ No □ Yes

For Continuation of Therapy, Please Respond to Additional Questions Below:

Hepatic Encephalopathy:

1. Does member have documentation of a clinically significant benefit from medication?
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

____
____
____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**

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