



**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: 12 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 #: \_\_\_\_\_

Do you have an approved provider referral number from Kaiser Permanente?

Yes – please provide your provider referral number here: \_\_\_\_\_

**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:**

Is the medication being prescribed by an Infectious Disease Specialist, a Gastroenterologist, OR if prescribing for hepatic encephalopathy, may be prescribed in consultation with Gastroenterology?

- No  Yes

### Hepatic Encephalopathy:

1. Does the patient have a diagnosis of hepatic encephalopathy?  
 No  Yes
2. Is the patient  $\geq 18$  years of age?  
 No  Yes
3. Is Xifaxan (rifaximin) being used as add-on therapy to lactulose?  
 No  Yes
4. Has the patient been unable to achieve an optimal response with lactulose monotherapy after receiving an adequate trial, OR does patient have intolerance or contraindication to lactulose?  
 No  Yes

### Irritable Bowel Syndrome with diarrhea:

1. Does the patient have a diagnosis of irritable bowel syndrome diarrhea predominant (IBS-D)?  
 No  Yes
2. Has the patient had inadequate response (must try for the minimum duration listed before considered treatment failure), contraindication or intolerance to at least TWO of the following medications?
  - Loperamide - at least 2 weeks
  - Diphenoxylate-atropine (Lomotil) - at least 2 weeks
  - A bile acid sequestrant (e.g., cholestyramine, colestipol) - at least 2 weeks
  - Dicyclomine (generic Bentyl) - at least 2 weeks
  - At least one tricyclic antidepressant - at least 6 weeks No  Yes
3. Has the patient received > 3 total treatments with rifaximin for IBS-D within the past 12 months (maximum 3 treatments with rifaximin per year)?  
 No  Yes

### C. difficile:

1. Does the patient have a diagnosis of third recurrence of *C. difficile* associated diarrhea?  
 No  Yes
2. Has the patient failed treatment with metronidazole and vancomycin for previous episodes?  
 No  Yes

Traveler's Diarrhea:

1. Does the patient have a diagnosis of Traveler's Diarrhea?  
 No  Yes
2. Is the patient intolerant or unable to take a fluoroquinolone?  
 No  Yes
3. Is the patient intolerant or allergic to azithromycin?  
 No  Yes

Small Intestinal Bacterial Overgrowth (SIBO)

1. Does the patient have a diagnosis of small intestinal bacterial overgrowth (SIBO)?  
 No  Yes
2. Has the patient experienced treatment failure with at least **ONE** of the following?
  - Amoxicillin-clavulanate
  - Ciprofloxacin
  - Trimethoprim-sulfamethoxazole
  - Metronidazole
  - Doxycycline
  - Tetracycline No  Yes

**For continuation of therapy (hepatic encephalopathy indication ONLY), please respond to additional questions below:**

Hepatic Encephalopathy:

1. Does the patient have a diagnosis of hepatic encephalopathy?  
 No  Yes
2. Is there 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:**

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

<b>Prescriber Signature:</b>	<b>Date:</b>
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