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: 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 ≥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:**

_____

_____

_____

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

Prescriber Signature:	**Date:**