



Montana Healthcare Programs  
Drug Prior Authorization Coverage Criteria

Xifaxan™ (rifaximin)

**Review Criteria**

Member must meet all the following criteria:

- Covered regardless of the Preferred Drug List status for the following diagnoses:
  - Hepatic encephalopathy:
    - Member must have had an unsuccessful trial on lactulose (2 days minimum)
    - Approval granted for 1 year
  - Irritable bowel syndrome without constipation (U.S. Food and Drug Administration [FDA]-indication)
    - Approval granted for initial 14-day therapy
    - Additional authorizations allowed for 2 additional treatments for the same flare
  - All other diagnosis must follow the Preferred Drug List requirements and/or standard of care requirements

Limitations:

- Hepatic encephalopathy: maximum daily dose is 550mg twice daily
- Irritable bowel syndrome without constipation: maximum daily dose is 550mg three times daily for 14 days