Rifaximin (Xifaxan®)

Goal:

- Optimize appropriate pharmacological management hepatic encephalopathy.

Length of Authorization:

- ~~6 months to~~ L~~L~~ifetime

Requires PA:

- Rifaximin

Covered Alternatives:

Preferred alternatives listed at www.orpdl.org

Approval Criteria		
1. What diagnosis is being treated?	Record ICD9 code.	
2. Is the treating diagnosis prevention or treatment of hepatic encephalopathy (572.2)?	**Yes:** Go to ~~4~~3	**No:** Pass to RPh. Deny; not funded by OHP or for medical appropriateness~~Go to 3~~
3. Is the patient currently managed with a~~n adequate~~ regularly scheduled daily ~~dose~~regimen of lactulose?	**Yes:** Go to 5	**No:** Go to ~~7~~4
4. Does the patient have a contraindication to lactulose?	**Yes:** Go to 5	**No:** Pass to RPh Deny; medical appropriateness Note: studies demonstrate effectiveness of rifaximin as add-on therapy to lactulose.
~~4.~~5. Is the patient currently prescribed a benzodiazepine drug?	**Yes:** Go to 6	**No:** Approve for lifetime
~~5.~~6. Is the patient tapering off the benzodiazepine? Note: tapering process may be several months	**Yes:** Approve for ~~1 year~~lifetime	**No:** Pass to RPh. Deny; medical appropriateness Note: studies explicitly excluded use of benzodiazepines and benzodiazepine-like drugs because of their risk for precipitating an episode of hepatic encephalopathy.~~ If justification is given for not tapering off the benzodiazepine, approve for 6 months.~~

Approval Criteria		
~~6. Does the patient have a contraindication to lactulose?~~	~~**Yes:** Approve for lifetime~~	~~**No:** Inform prescriber studies demonstrate effectiveness of rifaximin as add-on therapy to lactulose. If justification is given for not treating with lactulose, approve for 6 months.~~

P&T/DUR Review: *7/15; 5/15 (AG)*
Implementation *TBD*