Clinical Policy: Rifaximin (Xifaxan)

Reference Number: CP.PMN.47
Effective Date: 11.01.11
Last Review Date: 11.26
Line of Business: Commercial, HIM/ICHRA, Medicaid Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Rifaximin (Xifaxan®) is a rifamycin antibacterial.

FDA Approved Indication(s)

Xifaxan is indicated for the:

- Treatment of travelers' diarrhea (TD) caused by noninvasive strains of *Escherichia coli* in adult and pediatric patients 12 years of age and older
- Reduction in risk of overt hepatic encephalopathy (HE) recurrence in adults
- Treatment of irritable bowel syndrome with diarrhea (IBS-D) in adults

Limitation(s) of use in TD: Do not use in patients with diarrhea complicated by fever or blood in the stool or diarrhea due to pathogens other than *Escherichia coli.*

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results, or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Xifaxan is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Hepatic Encephalopathy (must meet all)**:**

1. Diagnosis of HE;
2. Age ≥ 18 years;
3. Failure of lactulose monotherapy in the past 30 days at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;*
   ** For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395*
4. Xifaxan is prescribed concurrently with lactulose, unless contraindicated or clinically significant adverse effects are experienced;
5. Dose does not exceed 1,100 mg (2 tablets) per day.

Approval duration:
HIM/ICHRA/Medicaid – 12 months
Commercial – 12 months or duration of request, whichever is less

B. Irritable Bowel Syndrome with Diarrhea (must meet all)**:**
1. Diagnosis of IBS-D;
2. Age ≥ 18 years;
3. Failure of an anti-diarrheal agent (e.g., loperamide) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;*
   ** For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395*
4. Failure of an antispasmodic (e.g., dicyclomine) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;*
   ** For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395*
5. Dose does not exceed 1,650 mg (3 tablets) per day.

Approval duration: 14 days

C. Travelers' Diarrhea (must meet all)**:**
1. Diagnosis of TD;
2. Age ≥ 12 years;
3. Failure of azithromycin 1,000 mg as a single dose, unless contraindicated or clinically significant adverse effects are experienced;*
   ** For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395*
4. Dose does not exceed 600 mg (3 tablets) per day.

Approval duration: 3 days

D. Small Intestinal Bacterial Overgrowth (off-label) (must meet all)**:**
1. Diagnosis of small intestinal bacterial overgrowth (SIBO);
2. Age ≥ 12 years;
3. Dose does not exceed 1,650 mg (3 tablets) per day.

Approval duration: Up to 14 days

E. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line

of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Hepatic Encephalopathy (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is receiving benefit from the referenced states for the applicable product and regulation (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Xifaxan is prescribed concurrently with lactulose, unless contraindicated or clinically significant adverse effects are experienced;
3. Member is responding positively to therapy;
4. If request is for a dose increase, new dose does not exceed 1,100 mg (2 tablets) per day.

Approval duration:
HIM/ICHRA/Medicaid – 12 months
Commercial – 12 months or duration of request, whichever is less

B. Irritable Bowel Syndrome with Diarrhea (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is receiving benefit from the referenced states for the applicable product and regulation (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member has not had ≥ three 14-day treatment courses that started within the last 6 months;
3. Member is responding positively to therapy;
4. If request is for a dose increase, new dose does not exceed 1,650 mg (3 tablets) per day.

Approval duration: 14 days

C. Travelers' Diarrhea

1. Re-authorization is not permitted. Members must meet the initial approval criteria. Review initial approval criteria for new cases of travelers' diarrhea unrelated to original medication request.

Approval duration: Not applicable

D. Small Intestinal Bacterial Overgrowth (off-label) (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;

b. Member is receiving benefit from the referenced states for the applicable product and regulation (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*

2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 1,650 mg (3 tablets) per day.

Approval duration: Up to 14 days

E. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
HE: hepatic encephalopathy
IBS-D: irritable bowel syndrome with diarrhea
SIBO: small intestinal bacterial overgrowth
TD: travelers' diarrhea

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose*
azithromycin (Zithromax®)	**TD** 1,000 mg PO single dose	500 mg/day PO is FDA-approved dosage; however, doses up to 1,200 mg/day PO are used off-label; 2 g PO when given as single dose
lactulose (Enulose®)	**HE** 30 to 45 mL, containing 20 g to 30 g of lactulose), PO TID-QID; may be adjusted every day or two to produce 2 or 3 soft stools daily	Specific maximum dosage information is not available
dicyclomine (Bentyl®)	**IBS-D** 20 mg PO QID	160 mg/day
hyoscyamine (Levsin®, Levbid®)	**IBS-D** Levsin: 0.125 – 0.25 mg PO Q 4h Levbid: 0.375 – 0.75 mg PO Q 12h	1.5 mg/day
loperamide (Imodium A-D®)	**IBS-D** 2 to 4 mg PO up to QID	16 mg/day
diphenoxylate/atropine (Lomotil®)	**IBS-D** Initially, 5 mg (2 tablets) PO QID; Discontinue after 10 days if clinical improvement is not observed	20 mg/day (of diphenoxylate)

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
**Maximum dose of the drug, not indication specific*

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): history of hypersensitivity to rifaximin, rifamycin antimicrobial agents, or any of the components of Xifaxan
- Boxed warning(s): none reported

Appendix C: General Information

- Per the 2014 hepatic encephalopathy practice guidelines by the American Association for the Study of Liver Diseases and 2026 American College of Gastroenterology hepatic encephalopathy guidelines, rifaximin is recommended as an add-on to lactulose therapy to prevent overt HE recurrence.
- Xifaxan 550 mg TID dosing regimens may be appropriate in the treatment of SIBO for patients with documented IBS. A trial by Scarpellini, et al. (2007) compared 80 adult patients with SIBO randomized to either 1,200 mg/day or 1,600 mg/day of Xifaxan for 7 days. 78.75% of the patient group had IBS. Using glucose breath test (GBT) normalization as an indicator for improved SIBO, 80% of patients on 1,600 mg/day had normalized GBT, compared to 58% of patients on 1,200 mg/day ($P < 0.05$, OR 1.82, 95% CI 1.09–8.01).

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
HE	550 mg PO BID	1,100 mg daily
IBS-D	550 mg PO TID for 14 days	1,650 mg daily
TD	Adults and children ≥ 12 years of age: 200 mg PO TID for 3 days	600 mg daily
SIBO‡	200 mg PO TID for 7 days OR 550 mg PO BID for 14 days 550 mg PO TID for 7 days may be considered in patients with SIBO and IBS	1,650 mg daily

‡*Off-label*

VI. Product Availability

Tablets: 200 mg, 550 mg

VII. References

1. Xifaxan Prescribing Information. Bridgewater, NJ: Salix Pharmaceuticals; October 2023. Available at: https://www.xifaxan.com/. Accessed July 10, 2026.
2. Clinical Pharmacology [database online]. Philadelphia, PA: Elsevier; 2018. Available at: http://www.clinicalkey.com/pharmacology.
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Hepatic Encephalopathy

4. Vilstrup H, Amodio P, Bajaj J, et al. Hepatic encephalopathy in chronic liver disease: 2014 practice guideline by AASLD-EASL. Hepatology. 2014; 60 (2): 715-735. Available at: https://www.aasld.org/sites/default/files/2019-06/hepaticencephalopathy82014.pdf. Accessed July 27, 2026.
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Small Intestinal Bacterial Overgrowth
12. Pimentel M, Saad RJ, Long MD, et al. ACG Clinical Guideline: Small Intestinal Bacterial Overgrowth. Am J Gastroenterol 2020;115:165-178. Available at: https://doi.org/10.14309/ajg.0000000000000501.
13. Lauritano EC, Gabrielli M, Lupascu A, et al. Xifaxan Dose-Find Study for the Treatment of Small Intestinal Bacterial Overgrowth. Aliment Pharmacol Ther. 2005 Jul 1;22(1):31-35.
14. Cuoco L, Salvagnini M. Small intestine bacterial overgrowth in irritable bowel syndrome: a retrospective study with rifaximin. Min Gastroentero Dietol. 2006;52(1):89-95.
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Reviews, Revisions, and Approvals	Date	P&T Approval Date
Q4 2022 annual review: added requirement for concurrent lactulose and rifaximin to initial criteria for HE per guidelines; references reviewed and updated.	07.26.22	11.22
Template changes applied to other diagnoses/indications and continued therapy section.	11.07.22	
4Q 2023 annual review: no significant changes; references reviewed and updated.	07.05.23	11.23
4Q 2024 annual review: no significant changes; references reviewed and updated.	07.16.24	11.24
4Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; for HE, updated initial approval duration from 6 to 12 months for Medicaid/HIM line of business; references reviewed and updated.	07.09.25	11.25
4Q 2026 annual review: no significant changes; added ICHRA line of business; references reviewed and updated.	07.10.26	11.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in

developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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