Clinical Policy: Prucalopride (Motegrity)

Reference Number: AZ.CP.PMN.194
Effective Date: 09.18.19
Last Review Date: 10.20 Revision Log
Line of Business: Arizona Medicaid (AzCH-CCP and Care1st)

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

Description

Prucalopride (Motegrity™) is a serotonin-4 (5-HT_4) receptor agonist.

FDA Approved Indication(s)

Motegrity is indicated for treatment of chronic idiopathic constipation (CIC) in adults.

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 Arizona Complete Health-Complete Care Plan and Care1st that Motegrity is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Idiopathic Constipation

1. Diagnosis of chronic idiopathic constipation;
2. Age ≥ 18 years;
3. Failure of one bulk forming laxative (e.g., psyllium [Metamucil®], unless all are contraindicated or clinically significant adverse effects are experienced;
4. Failure of one stimulant laxative (e.g., bisacodyl, senna), unless all are contraindicated or clinically significant adverse effects are experienced;
5. Failure of polyethylene glycol (MiraLax®) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
6. Failure of Amitiza® and Linzess®, unless contraindicated or clinically significant adverse effects are experienced;
   **Prior authorization may be required for Amitiza and Linzess*
7. Dose does not exceed 2 mg (1 tablet) per day.

Approval duration: 12 months

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): AZ.CP.PMN.53 for Arizona Medicaid.

II. Continued Therapy

A. Chronic Idiopathic Constipation (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 2 mg (1 tablet) per day.

Approval duration: 12 months

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

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): AZ.CP.PMN.53 for Arizona 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 – AZ.CP.PMN.53 for Arizona Medicaid.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

5-HT_4: serotonin-4
CIC: chronic idiopathic constipation
FDA: Food and Drug Administration

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
polyethylene glycol 3350 (MiraLax®)	17 g (approximately 1 heaping tablespoon) of powder in 120 to 240 mL of fluid PO once daily	34 grams per day
sennosides (Senokot®)	1 to 2 tablets (8.6 to 17.2 mg sennosides) PO twice daily	68.8 mg sennosides per day
bisacodyl (Dulcolax®)	5 to 15 mg/day (1 to 3 tablets) PO given as a single dose, or 1 suppository or retention enema (10 mg) PR once daily	15 mg per day PO or 10 mg per day PR

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	Either a suppository or oral tablet(s) may be used up to 3 times per week	
psyllium (Metamucil®)	1 rounded teaspoonful, tablespoonful, or premeasured packet in 240 mL of fluid PO, 1 to 3 times per day (2.4 g of soluble dietary fiber per dose)	7.2 g (as soluble dietary fiber) per day
calcium polycarbophil (FiberCon®)	1,000 mg PO 1 to 4 times per day or as needed	6,000 mg per day
methylcellulose (Citrucel®)	Caplet: 2 caplets (total 1 g methylcellulose) PO with at least 240 ml (8 oz) of liquid, up to 6 times per day as needed Powder: 1 heaping tablespoonful (2 g methylcellulose per 19 g powder) in at least 240 ml (8 oz) of water PO, given 1 to 3 times per day as needed	Caplet: 12 caplets per day Powder: 6 grams per day
Amitiza® (lubiprostone)	CIC: 24 mcg PO BID	CIC: 48 mcg/day
Linzess® (linaclotide)	CIC: 72 – 145 mcg PO QD	CIC: 145 mcg/day

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.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): hypersensitivity; intestinal perforation or obstruction due to structural or functional disorder of the gut wall, obstructive ileus, severe inflammatory conditions of the intestinal tract such as Crohn's disease, ulcerative colitis, and toxic megacolon/megarectum
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Chronic idiopathic constipation	Adults: 2 mg PO once daily For CrCl < 30 mL/min: 1 mg PO once daily	2 mg/day

VI. Product Availability

Tablets: 1 mg, 2 mg

VII. References

1. Motegrity Prescribing Information. Lexington, MA: Shire US Inc; December 2018. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/210166s000lbl.pdf. Accessed: September 16, 2019.
2. Camilleri M, Kerstens R, Rykx A, et al. A placebo-controlled trial of prucalopride for severe controlled constipation. N Engl J Med. 2008 May 29;358(22):2344-54.
3. Suares NC, Ford AC. Prevalence of, and risk factors for, chronic idiopathic constipation in the community: systematic review and meta-analysis. Am J Gastroenterol. 2011 Sep;106(9):1582-91.
4. Ke M, Zou D, Yuan Y, et al. Prucalopride in the treatment of chronic constipation in patients from the Asia-Pacific region: a randomized, double-blind, placebo-controlled study. Neurogastroenterol Motil. 2012 Nov; 24(11): 999–e541.
5. Yiannakou Y, Piessevaux H, Bouchoucha M, et al. A randomized, double-blind, placebo-controlled, phase 3 trial to evaluate the efficacy, safety, and tolerability of prucalopride in men with chronic constipation. Am J Gastroenterol 2015; 110:741–748.
6. Tack J, Van Outryve M, Beyens G, et al. Prucalopride (Resolor) in the treatment of severe chronic constipation in patients dissatisfied with laxatives. Gut. 2009 Mar;58(3):357-65.
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8. Piessevaux H, Corazziari E, Rey E, et al. A randomized, double-blind, placebo-controlled trial to evaluate the efficacy, safety, and tolerability of long-term treatment with prucalopride. Neurogastroenterol Motil. 2015 Jun;27(6):805-15.
9. American Paquette, I. M. et al. The American Society of Colon and Rectal Surgeons' clinical practice guideline for the evaluation and management of constipation. Dis. Colon Rectum 59, 479–492 (2016).

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	09.16.19	10.19
4Q 2020 annual review: no significant changes; references reviewed and updated	09.29.20	10.20
Added Care1st logo. Added verbiage to specify that criteria also applies to Care1st.	5.10.21	04.21

CLINICAL POLICY
Prucalopride

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.