Clinical Policy: Prucalopride (Motegrity)

Reference Number: CP.PMN.194
Effective Date: 01.29.19
Last Review Date: 11.25
Line of Business: Commercial*, Medicaid

Revision Log

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

Description

Prucalopride (Motegrity®) is a serotonin-4 (5-HT4) receptor agonist.

FDA Approved Indication(s)

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

** These criteria do NOT apply to California Exchange Plans. Requests for California Exchange Plans should be reviewed using HIM.PA.159.*

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 Motegrity and prucalopride are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Idiopathic Constipation

** These criteria do NOT apply to California Exchange Plans. Requests for California Exchange Plans should be reviewed using HIM.PA.159.*

1. Diagnosis of CIC;
2. Age ≥ 18 years;
3. Failure of all of the following laxatives (a, b, and c), unless clinically significant adverse effects are experienced or all are contraindicated:
   a. At least one bulk forming laxative (e.g., psyllium [Metamucil®], methylcellulose [Citrucel®], calcium polycarbophil [FiberCon®]);
   b. At least one stimulant laxative (e.g, bisacodyl, senna);
   c. At least one osmotic laxative (e.g., polyethylene glycol [MiraLax®])];
4. If request is for brand Motegrity, member must use generic prucalopride, unless contraindicated or clinically significant adverse effects are experienced;
5. Failure of generic lubiprostone, unless contraindicated or clinically significant adverse effects are experienced;
6. Dose does not exceed both of the following (a and b):
   a. 2 mg per day;
   b. 1 tablet per day.

Approval duration: 12 months

B. 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) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial 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 and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Chronic Idiopathic Constipation (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 currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. Failure of all of the following laxatives (a, b, and c), unless clinically significant adverse effects are experienced or all are contraindicated:
   a. At least one bulk forming laxative (e.g., psyllium [Metamucil®], methylcellulose [Citrucel®], calcium polycarbophil [FiberCon®]);
   b. At least one stimulant laxative (e.g, bisacodyl, senna);
   c. At least one osmotic laxative (e.g., polyethylene glycol [MiraLax®)];
4. If request is for brand Motegrity, member must use generic prucalopride, unless contraindicated or clinically significant adverse effects are experienced;
5. Failure of generic lubiprostone, unless contraindicated or clinically significant adverse effects are experienced;
6. If request is for a dose increase, new dose does not exceed both of the following (a and b):
   a. 2 mg per day;
   b. 1 tablet per day.

Approval duration: 12 months

B. 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) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial and CP.PMN.255 for Medicaid; or
b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial 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 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 and CP.PMN.53 for Medicaid, or evidence of coverage documents.

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 Either a suppository or oral tablet(s) may be used up to 3 times per week	15 mg per day PO or 10 mg per day PR
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

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
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
lubiprostone (Amitiza®)	CIC: 24 mcg PO BID	CIC: 48 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 to Motegrity; 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
CIC	Adults: 2 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; July 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/210166s004lbl.pdf. Accessed July 14, 2025.
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. 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.
5. 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 2016;59: 479–492.

6. Lin C, Chey WD, Imdad A, et al. American Gastroenterological Association-American College of Gastroenterology clinical practice guideline: Pharmacological management of chronic idiopathic constipation. Gastroenterology 2023;164:1086-1106.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2021 annual review: removed HIM line of business per March SDC; references reviewed and updated.	03.26.21	05.21
Per June SDC and prior clinical guidance, added requirement for use of generic lubiprostone.	06.02.21	08.21
2Q 2022 annual review: no significant changes; references reviewed and updated.	01.27.22	05.22
4Q 2022 annual review: no significant changes; references reviewed and updated. Template changes applied to other diagnoses/indications and continued therapy section.	08.18.22	11.22
4Q 2023 annual review: no significant changes; references reviewed and updated.	07.06.23	11.23
4Q 2024 annual review: no significant changes; references reviewed and updated.	07.12.24	11.24
Per December SDC, added the following clarification under the description and initial approval criteria sections: "These criteria do NOT apply to California Exchange Plans. Requests for California Exchange Plans should be reviewed using HIM.PA.159"; for continued therapy added similar step requirements to those listed for initial approval requests	12.02.24	02.25
Per March SDC, added redirection to generic prucalopride for initial approval criteria and continued therapy.	03.11.25	05.25
4Q 2025 annual review: no significant changes; references reviewed and updated.	07.14.25	11.25

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.