Commercial/Healthcare Exchange PA Criteria

Effective: May 2017

Prior Authorization: Trulance/Motegrity

Products Affected: Trulance (plecanatide) 3 mg oral tablet, Motegrity (prucalopride) 1 mg and 2 mg oral tablets

Covered Uses:

1. Chronic Idiopathic Constipation (Trulance OR Motegrity);
2. Irritable Bowel Syndrome with Constipation (Trulance ONLY)

Exclusion Criteria:

1. Pediatric patients
2. Patients with known or suspected mechanical gastrointestinal obstruction

Required Medical Information:

1. Diagnosis
2. Past medication trials

Age Restrictions: 18 years of age and older

Prescriber Restrictions: N/A

Coverage Duration: 12 Months

Other Criteria: ConnectiCare considers Trulance to be medically necessary for patients who meet all the following criteria:

1. Patient has clinically diagnosed chronic idiopathic constipation (Trulance OR Motegrity); or irritable bowel syndrome with constipation (Trulance ONLY)
2. Patient has had an intolerance to, or treatment failure of Amitiza **AND** Linzess
3. Patient will be using no more than 1 tablet per day

References:

1. TRULANCE(R) oral tablets, plecanatide oral tablets. Synergy Pharmaceuticals Inc (per manufacturer), New York, NY, 2018
2. Product Information: MOTEGRITY (TM) oral tablets, prucalopride oral tablets. Shire US Inc (per FDA), Lexington, MA, 2018.

Policy Revision history

Last Res. June 12th, 2019

Rev #	Type of Change	Summary of Change	Sections Affected	Date
1	New Policy	New Policy	All	5/2017
2	Policy Revision	Updated Template from CCI to EH CCI Carry over: P&T Review History: 5/17, 11/17, 11/18 Revision Record: 1/18, 9/18	All	4/25/2019
3	Policy Update	Addition of Motegrity; Change of policy name from Trulance to Trulance/Motegrity; Changed criteria from OR to AND requirements	All	6/12/2019