New Hampshire Medicaid Fee-for-Service Program

Drugs for Bowel Disorders/GI Motility, Chronic Criteria

Approval Date: June 10, 2024

Medications

Drug	Indication(s)
alosetron (Lotronex®)	• Treatment of severe, diarrhea-predominant irritable bowel syndrome (IBS-D) in women who have chronic IBS symptoms and have failed conventional therapy
eluxadoline (Viberzi®)	• Treatment of IBS-D in adult patients
linaclotide (Linzess®)	• Treatment of chronic idiopathic constipation (CIC) in adult patients • Treatment of irritable bowel syndrome with constipation (IBS-C) in adult patients • Treatment of functional constipation (FC) in pediatric patients 6 to 17 years of age
lubiprostone (Amitiza®)	• Treatment of CIC in adult patients • Treatment of IBS-C in females ≥ 18 years old • Treatment of opioid-induced constipation (OIC) in adults with chronic, non-cancer pain, including patients with chronic pain related to prior cancer or its treatment who do not require frequent (i.e., weekly) opioid dosage escalation
methylnaltrexone (Relistor®)	• Treatment of OIC in adult patients with advanced illness or pain caused by active cancer who require opioid dosage escalation for palliative care (injection only) • Treatment of OIC in patients taking opioids for chronic non-cancer pain, including patients with chronic pain related to prior cancer or its treatment who do not require frequent (i.e., weekly) opioid dosage escalation (tablet and injection formulations)
naldemedine (Symproic®)	• Treatment of OIC in adult patients with chronic non-cancer pain, including patients with chronic pain related to prior cancer or its treatment who do not require frequent (i.e., weekly) opioid dosage escalation
naloxegol (Movantik®)	• Treatment of OIC in adult patients with chronic non-cancer pain, including patients with chronic pain related to prior cancer or its treatment who do not require frequent (i.e., weekly) opioid dosage escalation
plecanatide (Trulance™)	• Treatment of CIC in adult patients • Treatment of IBS-C in adult patients
prucalopride (Motegrity®)	• Treatment of CIC in adult patients
tenapanor (Ibsrela®)	• Treatment of adults with IBS-C in adult patients

Criteria for Approval

1. Approved FDA indication and age range.
2. For request for diagnosis of chronic constipation defined as on average, less than three spontaneous bowel movements per week with constipation symptoms for at least three months, patient must have:
   - Treatment failure on polyethylene glycol 3350 (MiraLAX®); **AND**
   - Treatment failure on lactulose oral 60 mL total daily dose.

Length of Authorization: Six months

Criteria for Denial

1. Prior approval will be denied if the approval criteria are not met; **OR**
2. History of mechanical gastrointestinal obstruction; **OR**
3. Pregnancy (excludes Amitiza®, Movantik® or Relistor®).

Non-preferred drugs on the Preferred Drug List (PDL) require additional prior authorization.

References

Available upon request.

Revision History

Reviewed by	Reason for Review	Date Approved
Pharmacy & Therapeutic Committee	New	10/25/2007
Commissioner	New	11/20/2007
Pharmacy & Therapeutic Committee	Update	04/16/2009
Commissioner	Approval	05/12/2009
DUR Board	Revision	06/15/2011
Commissioner	Revision	09/29/2011
N/A	New FDA approved indication	07/10/2014
DUR Board	New Drug to Market	05/12/2015
Commissioner	Approval	06/30/2015
DUR Board	Update	05/31/2016
Commissioner	Approval	06/18/2016
DUR Board	Update	09/27/2018
Commissioner Designee	Approval	11/27/2018
DUR Board	Update	10/28/2019
Commissioner Designee	Approval	12/03/2019

Reviewed by	Reason for Review	Date Approved
DUR Board	Update	06/30/2020
Commissioner Designee	Approval	08/07/2020
DUR Board	Update	06/08/2021
Commissioner Designee	Approval	08/13/2021
DUR Board	Update	12/13/2022
Commissioner Designee	Approval	01/26/2023
DUR Board	Revision	05/07/2024
Commissioner Designee	Approval	06/10/2024