

Clinical Policy: Linaclotide (Linzess)

Reference Number: CP.PMN.71

Effective Date: 11.01.15

Last Review Date: 11.19

Line of Business: HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Linaclotide (Linzess[®]) is a guanylate cyclase-C agonist.

FDA Approved Indication(s)

Linzess is indicated in adults for the treatment of:

- Irritable bowel syndrome with constipation (IBS-C)
- Chronic idiopathic constipation (CIC)

Policy/Criteria

Provider must submit documentation (including 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 Linzess is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Irritable Bowel Syndrome with Constipation (must meet all):

1. Diagnosis of IBS-C;
2. Age \geq 18 years;
3. Failure of one bulk forming laxative (e.g., psyllium (Metamucil[®]), methylcellulose (Citrucel[®]), calcium polycarbophil (FiberCon[®])), unless contraindicated or clinically significant adverse effects are experienced;
4. Dose does not exceed 290 mcg (1 capsule) per day.

Approval duration: 12 months

B. Chronic Idiopathic Constipation (must meet all):

1. Diagnosis of CIC;
2. Age \geq 18 years;
3. Failure of one bulk forming laxative (e.g., psyllium [Metamucil], methylcellulose [Citrucel], calcium polycarbophil [FiberCon]), 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. Dose does not exceed 145 mcg (1 capsule) per day.

Approval duration: 12 months

C. 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): HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (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:
 - a. IBS-C: 290 mcg (1 capsule) per day;
 - b. CIC: 145 mcg (1 capsule) 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): HIM.PHAR.21 for health insurance marketplace 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 – HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CIC: chronic idiopathic constipation
 FDA: Food and Drug Administration
 IBS-C: irritable bowel syndrome with constipation

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
psyllium (Metamucil®)	1 rounded teaspoonful, tablespoonful, or premeasured packet in 240 mL of fluid	7.2 g (as soluble dietary fiber) per day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	PO, 1 to 3 times per day (2.4 g of soluble dietary fiber per dose)	
calcium polycarbophil (FiberCon [®])	1,000 mg 1 to 4 times per day or as needed	6,000 mg/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/day Powder: 6 grams/day
sennosides (Senokot [®])	1 to 2 tablets (8.6 to 17.2 mg sennosides) PO BID	68.8 mg sennosides/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 QD Either a suppository or oral tablet(s) may be used up to 3 times per week	15 mg/day PO or 10 mg/day PR
polyethylene glycol 3350 (MiraLax [®])	17 g (approximately 1 heaping tablespoon) of powder in 120 to 240 mL of fluid PO QD	34 g/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): patients with known or suspected mechanical gastrointestinal obstruction; patients less than 6 years of age due to the risk of serious dehydration
- Boxed warning(s): risk of serious dehydration in pediatric patients

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
IBS-C	290 mcg PO QD	290 mcg/day
CIC	72 mcg or 145 mcg PO QD	145 mcg/day

VI. Product Availability

Capsules: 72 mcg, 145 mcg, and 290 mcg

VII. References

1. Linzess Prescribing Information. Irvine, CA: Allergan; October 2018. Available at: <https://www.linzess.com/>. Accessed August 5, 2019.

2. Ford AC, Moayyedi P, Lacy BE, et al. American College of Gastroenterology monograph on the management of irritable bowel syndrome and chronic idiopathic constipation. Am J Gastroenterol 2014; 109: S2-S26.
3. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2019. Available at: <http://www.clinicalpharmacology-ip.com/>. Accessed August 5, 2019.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New guideline created	09.15	11.15
Converted to new integrated template. Added FDA max recommended dose and health plan approved QL requirement; -IBS-C: removed requirement related to failure of adherent use of polyethylene glycol (PEG) per recommendations from American College of Gastroenterology that there is no evidence that PEG formulations alleviate pain or provide overall symptom relief in IBS. -CIC: Added language of “unless contraindicated to such therapies” to requirement related to aforementioned medication trials must have occurred within the past 90 days; Updated references to reflect current literature search	08.16	11.16
Converted to new template. Updated max dose requirement to include specific QL. Added a requirement that member is responding positively to therapy on re-auth.	08.22.17	11.17
1Q18 annual review. - Policies combined for Medicaid and marketplace lines of business - Removed duration and timeframe of trial related to laxative use since they are available OTC and may not be verifiable via claims history - Medicaid: modified initial approval duration from 6 to 12 months for both indications - References reviewed and updated.	11.07.17	02.18
4Q 2018 annual review: no significant changes from previously approved corporate policy; references reviewed and updated.	07.30.18	11.18
4Q 2019 annual review: no significant changes from previously approved corporate policy; references reviewed and updated.	08.05.19	11.19

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.

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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.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.

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