Are your CIC patients looking for a different treatment approach?

If you have a patient with Chronic Idiopathic Constipation (CIC) who is looking for something different, it may be a sign that their current approach may not be working for them.

Have your patients:

- ☐ Expressed frustration with recurring symptoms?
- ☐ Had less than 3 complete spontaneous bowel movements per week?
- ☐ Felt a sense of incomplete evacuation?
- ☐ Asked about dosing frequency?
- ☐ Stopped taking their CIC medication as prescribed?

Colonic dysmotility could be a factor affecting your CIC patients[1]

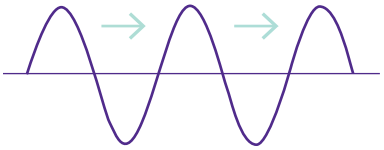
> **Consider a prokinetic approach for patients looking for a treatment that works differently**

Target the muscle behind colonic motility

A different class of CIC treatment

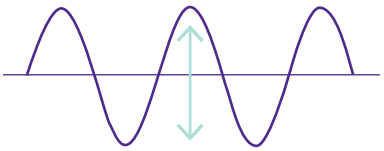
Motegrity is the only FDA-approved selective serotonin type 4 (5-HT_4) receptor agonist for adults with CIC. It functions as a GI prokinetic that stimulates colonic peristalsis (i.e. high amplitude propagating contractions (HAPCs)), which increases bowel motility.[2-5]

In a pharmacodynamic CIC study:



More frequent HAPCs

A single 2 mg dose of Motegrity increased HAPC frequency during the first 12 hours compared to osmotic laxatives[3]



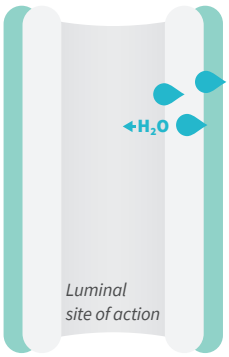
Increased HAPC amplitude

Motegrity 4 mg* once daily for 7 days increased HAPC amplitude compared to placebo without affecting colonic phasic activity[3]

*Twice the max recommended dose of 2 mg.

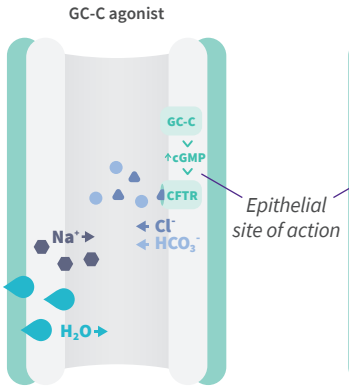
Treatment mechanisms in the management of CIC

Osmotic laxatives

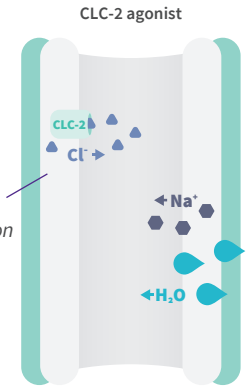


Create an osmotic gradient that draws water into the intestinal lumen.[2,6,7]

Prosecretory agents

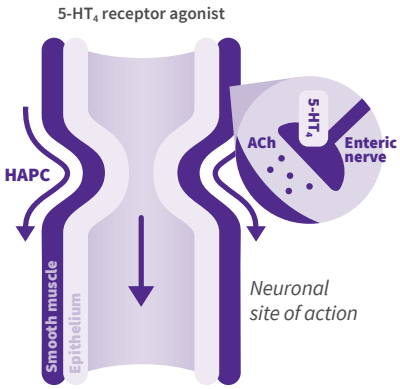


Activate GC-C receptors, leading to increased secretion of Cl- and HCO_3^-, followed by Na+ and water.[2,6,8,9]



Activate CLC-2 channels, increasing Cl- secretion, followed by Na+ and water.[2,6,9]

Serotonergic agents



Activate 5-HT_4 receptors, promoting ACh release, colonic smooth muscle contractions and peristalsis.[2-4,10]

Overview of treatment mechanism is not a comparison of treatment safety or efficacy.
These are not all the current treatments or rescue medications for adults with CIC.

The above are illustrations of colons. The diagrams are a simplified representation of the purported primary MOA.
For more information, visit motegrityhcp.com

ACh=acetylcholine; CFTR=cystic fibrosis transmembrane conductance regulator; cGMP=cyclic guanosine monophosphate; CLC-2=chloride channel-type 2; GC-C=guanylate cyclase-C; HAPC=high amplitude propagating contraction.

INDICATION

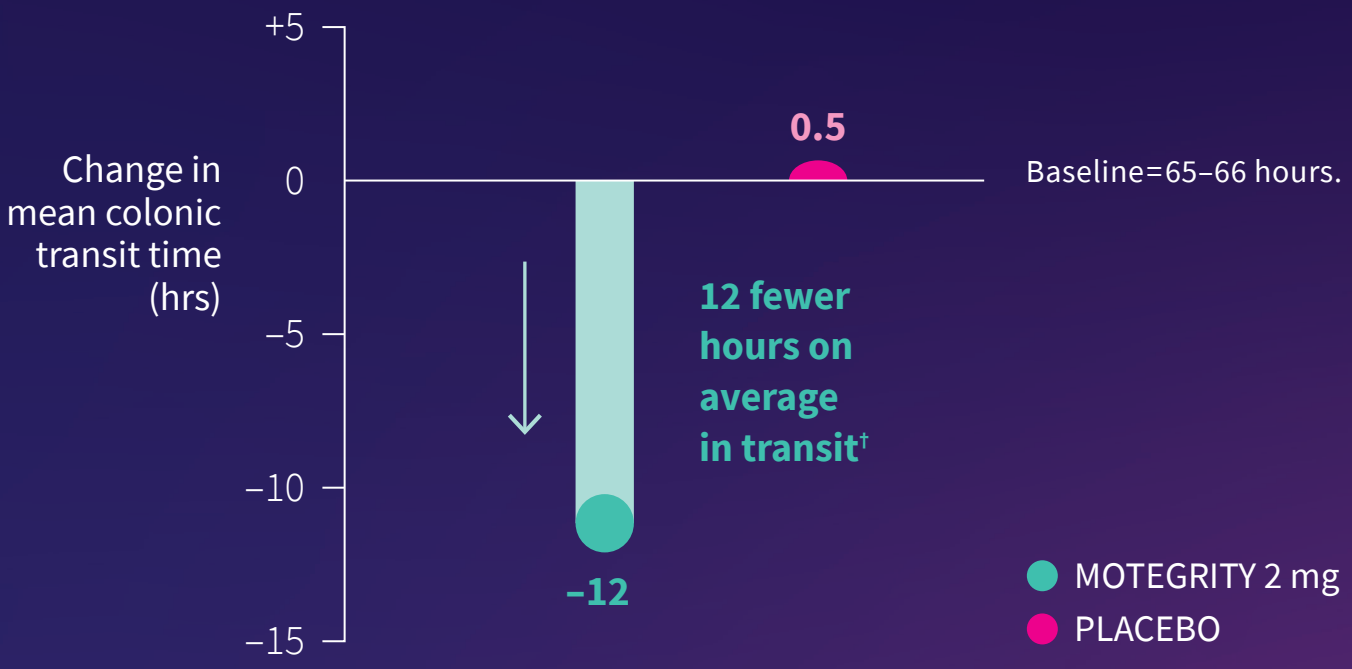
Motegrity® (prucalopride) is a serotonin-4 (5-HT_4) receptor agonist indicated for the treatment of chronic idiopathic constipation (CIC) in adults.

Please see additional Important Safety Information throughout and full Prescribing Information.

motegrity®
(prucalopride) tablets 1mg, 2mg

Accelerate colonic transit time (CTT) in adults with CIC*[3,11]

Motegrity 2 mg reduced mean CTT by 12 hours vs. baseline†



*Results from an integrated analysis of 3 randomized, placebo-controlled, dose-finding trials in adults (n=280) with CIC. Mean change in CTT was –12 hours (from a baseline=65 hrs) with Motegrity 2 mg group vs. +0.5 hrs (baseline=66 hrs) in the placebo group.
†*P*<0.001 vs. baseline.

IMPORTANT SAFETY INFORMATION

Contraindications

- Hypersensitivity to Motegrity. Reactions including dyspnea, rash, pruritus, urticaria, and facial edema have been observed
- 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

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Consider a **prokinetic approach** for patients looking for a different CIC treatment

With Motegrity, it's possible to take adult CIC Patients from

STASIS TO *PERISTALSIS*

Stimulated colonic peristalsis is possible with Motegrity, the only FDA-approved *selective* serotonin type 4 (5-HT_4) receptor agonist for adults with CIC.[2-5]

Visit motegrityhcp.com to learn more.

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Warnings and Precautions

Suicidal Ideation and Behavior: In clinical trials, suicides, suicide attempts and suicidal ideation have been reported. Postmarketing cases of suicidal ideation and behavior as well as self-injurious ideation and new onset or worsening of depression have been reported within the first few weeks of starting Motegrity. A causal association between treatment with Motegrity and an increased risk of suicidal ideation and behavior has not been established. Monitor patients for new onset or worsening of depression and emergence of suicidal thoughts and behavior. Instruct patients to discontinue Motegrity immediately and contact their healthcare provider if they experience any of these symptoms.

Adverse Reactions

Most common adverse reactions (≥2%) are headache, abdominal pain, nausea, diarrhea, abdominal distension, dizziness, vomiting, flatulence, and fatigue.

Use in Specific Populations

- **Lactation:** Motegrity is present in breast milk. Consider risks and benefits of breastfeeding
- **Pediatric:** Safety and effectiveness in pediatric patients have not been established
- **Renal Impairment:** A decreased dosage is recommended in patients with severe renal impairment. Avoid Motegrity in patients with end-stage renal disease requiring dialysis

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References: 1. Dinning P, Di Lorenzo C, et al. *Best Pract Res Clin Gastroenterol*. 2011;25:89-101. **2.** Camilleri M, Ford AC, Mawe GM, et al. *Nat Rev Dis Primers*. 2017;3:17095. **3.** Motegrity (prucalopride) Prescribing Information. Lexington, MA: Shire LLC. **4.** Mawe GM, Hoffman JM. *Nat Rev Gastroenterol Hepatol*. 2013;10(8):473-486. **5.** Tack J, Camilleri M, Chang L, et al. *Aliment Pharmacol Ther*. 2012;35(7):745-767. **6.** Lacy B, Hussain Z, Mearin F. *Neurogastroenterol Motil*. 2014;26(6):749-763. **7.** Izzy M, Malieckal A, Little E, et al. *World J Gastrointest Pharmacol Ther*. 2016;7(2):334-342. **8.** Lacy BE, Levenick JM, Crowell M. *Therap Adv Gastroenterol*. 2012;5(4):233-247. **9.** Menees S, Saad R, Chey WD. *Nat Rev Gastroenterol Hepatol*. 2012;9(11):661-674. **10.** Gershon MD, Tack J. *Gastroenterology*. 2007;132(1):397-414. **11.** Emmanuel A, Cools M, Vandeplassche L, Kerstens R. *Am J Gastroenterol*. 2014;109(6):887-894.

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