Hypnotic Agents
Lunesta (eszopiclone); Rozerem (ramelteon); Belsomra (suvorexant); zolpidem extended-release tablet; Zolpimist (zolpidem oral spray); Edluar (zolpidem sublingual tablet); Intermezzo (zolpidem sublingual tablet)

Effective: 10/1/15

<table>
<thead>
<tr>
<th>Clinical documentation and prior authorization required</th>
<th>✓</th>
<th>Type of review – case management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not covered</td>
<td>Type of review – clinical review Fax: 617-673-0988</td>
<td></td>
</tr>
<tr>
<td>Pharmacy (RX) or medical (MED) benefit</td>
<td>RX Department to review RxUM</td>
<td></td>
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</table>

OVERVIEW
FDA-APPROVED INDICATIONS

Since sleep disturbances may be the presenting manifestation of a physical and/or psychiatric disorder, symptomatic treatment of insomnia should be initiated only after a careful evaluation of the patient. The failure of insomnia to remit following a reasonable period of treatment may indicate the presence of a primary psychiatric and/or medical illness that requires evaluation. Worsening of insomnia, or the emergence of new cognitive or behavioral abnormalities, may be the result of an unrecognized underlying psychiatric or physical disorder requiring further evaluation.

Ambien® (zolpidem tartrate conventional tablets) is indicated for the short-term treatment of insomnia characterized by difficulties with sleep initiation. Ambien has been shown to decrease sleep latency and increase the duration of sleep for up to 35 days in controlled clinical studies. The clinical trials performed in support of efficacy were four to five weeks in duration with the final formal assessments of sleep latency performed at the end of treatment.

Ambien CR® (zolpidem extended-release) is indicated for the treatment of insomnia characterized by difficulties with sleep onset and/or sleep maintenance (as measured by wake time after sleep onset). The clinical trials performed in support of efficacy were up to 3 weeks (using polysomnography measurement up to 2 weeks in both adult and elderly patients) and 24 weeks (using patient-reported assessment in adult patients only) in duration.

Lunesta® (eszopiclone) is indicated for the treatment of insomnia. In controlled outpatient and sleep laboratory studies, Lunesta administered at bedtime decreased sleep latency and improved sleep maintenance. The clinical trials performed in support of efficacy were up to six months in duration. The final formal assessments of sleep latency and maintenance were performed at four weeks in the six-week study (adults only), at the end of both two-week studies (elderly only) and at the end of the six-month study (adults only).

Rozerem® (ramelteon) is indicated for the treatment of insomnia characterized by difficulty with sleep onset. The clinical trials preformed in support of efficacy were up to 6 months in duration. The final formal assessments of sleep latency were performed after 2 days of treatment during the crossover study (elderly only), at 5 weeks in the 6 week studies (adults and elderly), and at the end of the 6 month stud (adults and elderly).

Sonata® (zaleplon) is indicated for the short-term treatment of insomnia. Sonata has been shown to decrease the time to sleep onset for up to 30 days in controlled clinical studies. It has not been shown to increase total sleep time or decrease the number of awakenings. The clinical trials performed in support of efficacy ranged from a single night to five weeks in duration. The final formal assessments of sleep latency were performed at the end of treatment.

Belsomra® (suvorexant) is an orexin receptor antagonist indicated for the treatment of insomnia, characterized by difficulties with sleep onset and/or sleep maintenance.

<table>
<thead>
<tr>
<th>Generic name (Brand name)</th>
<th>Strengths</th>
<th>Maximum recommended daily dose*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eszopiclone (Lunesta)</td>
<td>1mg, 2mg, 3mg</td>
<td>3mg/day</td>
</tr>
<tr>
<td>Ramelteon (Rozerem)</td>
<td>8mg</td>
<td>8mg/day</td>
</tr>
<tr>
<td>Suvorexant (Belsomra)</td>
<td>5 mg, 10 mg, 15 mg, 20 mg</td>
<td>20mg/day</td>
</tr>
<tr>
<td>Zaleplon (Sonata)</td>
<td>5mg, 10mg</td>
<td>20mg/day</td>
</tr>
<tr>
<td>Zolpidem, IR (Ambien)</td>
<td>5mg, 10mg</td>
<td>10mg/day</td>
</tr>
<tr>
<td>Hypnotic Agent</td>
<td>Dosage</td>
<td>Coverage Criteria</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
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<tr>
<td>Zolpidem, ER (Ambien CR)</td>
<td>6.25mg, 12.5mg</td>
<td>12.5mg/day</td>
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<tr>
<td>Zolpidem, SL tablets (Edluar)</td>
<td>5mg, 10mg</td>
<td>10mg/day</td>
</tr>
<tr>
<td>Zolpidem, SL tablets (Intermezzo)</td>
<td>1.75 mg, 3.5 mg</td>
<td>1.75 mg/day for women, 3.5 mg/day for men</td>
</tr>
<tr>
<td>Zolpidem, Oral Spray (Zolpimist)</td>
<td>5mg/actuation</td>
<td>10mg/day</td>
</tr>
</tbody>
</table>

*The recommended initial dosage of zolpidem immediate-release tablets for sleep onset is 5 mg for women and 5 mg or 10 mg for men. The recommended initial dosage of zolpidem controlled-release tablets for sleep onset is 6.25 mg for women and 6.25 mg or 12.5 mg for men.

**PHARMACY COVERAGE GUIDELINES**

Tufts Health Plan – Network Health may authorize coverage of a nonpreferred hypnotic agent for members when all the following criteria for a particular regimen are met and limitations do not apply:

For members at least 6 years of age and older,
- The member tried and failed therapy of at least 30 days duration with both zaleplon and zolpidem (immediate-release), or the provider indicates clinical inappropriateness of treatment with both zaleplon and zolpidem (immediate-release) AND
- If the request is for suvorexant (Belsomra), the member must also try and fail a course of therapy of at least 30 days duration with controlled-release zolpidem.

For members less than 6 years of age,
- The members has been evaluated by a specialist AND
- The request is for an FDA approved diagnosis or for an off-label use supported by recognized medical compendia AND
- One of the following:
  - The member was recently hospitalized for a behavioral health condition.
  - The member has a history of severe risk or harm to oneself or others.

**LIMITATIONS**

- The coverage of hypnotic agents is limited to one unit per day.
- Requests for quantities that exceed the quantity limit will be reviewed according to the Quantity Limit criteria.
- The length of approval will be for one year; subsequent approval will require the member had an office visit and was reassessed for this condition within the past year, and continued therapy with this medication is considered medically necessary.
- Requests for brand-name products, which have AB-rated generics, will be reviewed according to Brand Name criteria.

**CODES**

None

**REFERENCES**


**APPROVAL HISTORY**
- 06/04/2014: Reviewed by the Pharmacy and Therapeutics Committee.
- 03/10/2015: Reviewed by the Pharmacy and Therapeutics Committee; approval duration modified to one year.
- 06/09/2015: Reviewed by the Pharmacy and Therapeutics Committee; added criteria for Belsomra; added criteria for children less than 6 years of age.

**BACKGROUND, PRODUCT, AND DISCLAIMER INFORMATION**
Pharmacy Medication Request Guidelines have been developed for determining coverage for Tufts Health Plan – Network Health benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with the applicable Member Handbook and in coordination with the member’s physician(s). Pharmacy Medication Request Guidelines are developed for selected therapeutic classes or drugs found to be safe but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the Tufts Health Plan – Network Health service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts Health Plan – Network Health reviews Pharmacy Medication Request Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Pharmacy Medication Request Guidelines apply to fully insured Tufts Health Together offerings unless otherwise noted in this policy or the applicable Member Handbook. Check the Preferred Drug List (formulary) in the pharmacy section of our website to determine if the drug requires you to get prior authorization.

For Tufts Health Direct (individual and small-group plan), please refer to the Tufts Health Direct Pharmacy Medical Necessity Guidelines.

For Tufts Health Unify (Medicare-Medicaid One Care for people ages 21 – 64), please refer to the Tufts Health Unify Prior Authorization Medical Necessity Guidelines.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines, when applicable, and adherence to plan policies and procedures and claims editing logic.