Pharmacy Medical Necessity Guidelines: Hypnotic Agents

Effective: August 14, 2017

<table>
<thead>
<tr>
<th>Prior Authorization Required</th>
<th>Type of Review – Care Management</th>
<th>√</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Covered</td>
<td>Type of Review – Clinical Review</td>
<td>√</td>
</tr>
</tbody>
</table>

Pharmacy (RX) or Medical (MED) Benefit | RX | Department to Review | RXUM

This Pharmacy Medical Necessity Guideline applies to the following:

**Tufts Health Plan Commercial Plans**
- Tufts Health Plan Commercial Plans – large group plans
- Tufts Health Plan Commercial Plans – small group and individual plans

**Tufts Health Public Plans**
- Tufts Health Direct – Health Connector
- Tufts Health Together – A MassHealth Plan
- Tufts Health RITogether – A RIte Care + Rhody Health Partners Plan

**Tufts Health Freedom Plan products**
- Tufts Health Freedom Plan - large group plans
- Tufts Health Freedom Plan - small group plans

Fax Numbers:

- RXUM: 617.673.0988

OVERVIEW

**FDA-APPROVED INDICATIONS**

Ambien® (zolpidem tartrate immediate release 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 performed 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 study (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.

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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>Zolpidem, ER (Ambien CR)</td>
<td>6.25mg, 12.5mg</td>
<td>12.5mg/day</td>
</tr>
<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.

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.

The goal of the MassHealth Pediatric Behavioral Health Medication Initiative (PBHMI) is to encourage safe prescribing of behavioral health medication regimens to members less than 18 years of age. As part of the PBHMI, a prior authorization is required for pediatric members less than 6 years of age who are being prescribed a hypnotic agent, regardless as to whether or not the hypnotic is preferred on the Plan's formulary.

**COVERAGE GUIDELINES**

In addition to medication-specific criteria, the Plan may authorize coverage of a preferred or non-preferred hypnotic medication for Members less than 6 years of age when the following criteria are met:

**For Members less than 6 years of age:**

Belsomra (suvorexant), Edluar (zolpidem SL), eszopiclone, Silenor (doxepin), temazepam 7.5 mg and 22.5 mg, zolpidem extended release tablet, zolpidem SL (Intermezzo), ZolpiMist (zolpidem)

1. All of the following criteria are met:
   a) Treatment plan including name of the current hypnotic agent and corresponding diagnosis
   AND
   b) Prescriber is a specialist (e.g., neurologist, psychiatrist) or a consult is provided

**Estazolam, flurazepam, temazepam 15 mg and 30 mg, triazolam, zaleplon, zolpidem**

1. For the diagnosis of insomnia with other behavioral health comorbidities (excluding ADHD):
   a) Member has a treatment plan, including the name of the current hypnotic agent and corresponding diagnosis
   AND
   b) Prescriber is a specialist (e.g., neurologist, psychiatrist) or a consult is provided
   OR

2. For the diagnosis of insomnia with comorbid ADHD:
   a) Member has a treatment plan, including the name of current hypnotic agent and corresponding diagnosis
b) Prescriber is a specialist (e.g., neurologist, psychiatrist) or a consult is provided

AND

c) An inadequate response (defined as ten or more days of therapy), adverse reaction, or contraindication to melatonin

AND

d) An inadequate response (defined as ten or more days of therapy), adverse reaction, or contraindication to clonidine

OR

3. For the diagnosis of insomnia without behavioral health comorbidities:
   a) Member has a treatment plan, including name of current hypnotic agent and corresponding diagnosis

   AND

   b) Prescriber is a specialist (e.g., neurologist, psychiatrist) or a consult is provided

   AND

   c) An inadequate response (defined as ten days or more of therapy), adverse reaction, or contraindication to melatonin

For all Members:

The plan may authorize coverage of a nonpreferred hypnotic agent for Members when all of the following criteria for a particular regimen are met:

1. Member had an inadequate response (defined as at least 30 days’ duration), intolerance, or contraindication to all of the following:
   a) zaleplon
   b) zolpidem immediate-release

   AND

2. Belsomra (suvorexant) only: Member had an inadequate response (defined as at least 30 days’ duration), intolerance, or contraindication to zolpidem controlled-release

LIMITATIONS

1. The coverage of hypnotic agents is limited to one unit per day.
2. The length of approval will be for one year; subsequent approval will require the Member had an office visit and was re-assessed for this condition within the past year, and continued therapy with this medication is considered medically necessary.
3. Requests for brand-name products, which have AB-rated generics, will be reviewed according to Brand Name criteria.

CODES

None

REFERENCES


APPROVAL HISTORY
June 4, 2014: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
- March 10, 2015: Approval duration modified to one year.
- June 9, 2015: Added criteria for Belsomra; added criteria for children less than 6 years of age.
- January 1, 2016: Administrative change to rebranded template.
- August 9, 2016: Updated criteria for children less than 6 years of age.
- April 11, 2017: Administrative update, adding Tufts Health RITogether to the template
- August 8, 2017: Administrative update. Clarified that criteria for nonpreferred hypnotics applies to members of all ages.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION
Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with a Member's benefit document and in coordination with the Member's physician(s). The plan makes coverage decisions on a case-by-case basis considering the individual Member's health care needs. Pharmacy Medical Necessity 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 service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

This Pharmacy Medical Necessity Guideline does not apply to Uniformed Services Family Health Plan Members or to certain delegated service arrangements. Unless otherwise noted in the Member's benefit document or applicable Pharmacy Medical Necessity Guideline, Pharmacy Medical Necessity Guidelines do not apply to CareLink® Members. For self-insured plans, drug coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a coverage guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence. For Tufts Health Plan Medicare Preferred, please refer to Tufts Health Plan Medicare Preferred Prior Authorization Criteria.

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.