# Clinical Policy: Agents for Insomnia

Reference Number: AZ.CP.PMN.1016
Effective Date: 07.16
Last Review Date: 11.21
Line of Business: Arizona Medicaid (AzCH-CCP and Care1st) Revision Log

**See Important Reminder at the end of this policy for important regulatory and legal information.**

## Description

The following are sleep medications indicated for insomnia that require prior authorization: suvorexant (Belsomra®), zolpidem CR (Ambien CR®), zolpidem sublingual tablets (Edluar®, Intermezzo®), zolpidem spray (Zolpimist®), estazolam (Prosom), Eszopiclone (Lunesta), Flurazepam (Dalmane), lemborexant (Dayvigo), ramelteon (Rozerem®), doxepin (Silenor®), temazepam (restoril) 7.5mg & 22.5mg, triazolam (Halcion), and zaleplon (Sonata)

**AHCCCS preferred drugs** in this class include: Eszopiclone, Rozerem (brand only), Temazepam 15mg & 30mg, Zolpidem 5mg &10mg.

**AHCCCS non-preferred drugs** in this class include: Ambien, Belsomra, Dayvigo, Edluar, estazolam, flurazepam, Halcion, Intermezzo, Lunesta, Prosom, ramelteon, Silenor, Sonata, triazolam, zaleplon, Zolpidem CR, Zolpimist.

## FDA approved indications

Belsomra is indicated for treatment of insomnia, characterized by difficulties with sleep onset and/or sleep maintenance.

Lemborexant (Dayvigo) is indicated for the treatment of adult patients with insomnia, characterized by difficulties with sleep onset and/or sleep maintenance.

Edluar and Zolpimist are indicated for short-term treatment of insomnia characterized by difficulties with sleep initiation.

Eszopiclone (Lunesta) is indicated for the treatment of insomnia.

Estazolam (Prosom) and flurazepam are indicated for short term treatment of insomnia characterized by difficulty falling asleep, frequent nocturnal awakenings, and/or early morning awakenings.

Zolpidem CR is indicated for the short-term treatment of insomnia characterized by difficulty with sleep onset and/or sleep maintenance.

Intermezzo is indicated for treatment of insomnia when a middle-of-the-night awakening is followed by difficulty returning to sleep.

Limitation(s) of use: Intermezzo is not indicated for the treatment of middle-of-the night awakening when the patient has fewer than 4 hours of bedtime remaining before the planned time of waking.

Rozerem is indicated for treatment of insomnia characterized by difficulty with sleep onset.

Silenor is indicated for treatment of insomnia characterized by difficulties with sleep maintenance.

Triazolam (Halcion) and zaleplon (Sonata) are indicated for the short-term treatment of insomnia.

**Policy/Criteria**
*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of Arizona Complete Health-Complete Care Plan and Care1st that the above listed medications are **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria**

**A. Insomnia** (must meet all)**:**

1. Diagnosis of insomnia;
2. For Rozerem (BRAND) only:
    a. Failure of 2 preferred agents (eszopiclone, temazepam, or zolpidem), unless contraindicated or clinically significant adverse effects are experienced;
3. For Silenor only: both of the following (a **AND** b):
    a. Failure of trials of 2 preferred sedative, hypnotic agents (eszopiclone, temazepam 15 mg & 30 mg, and zolpidem) unless contraindicated or clinically significant adverse effects are experienced;
    b. Failure of low dose doxepin unless contraindicated or clinically significant adverse effects are experienced;
4. For zolpidem sublingual tablets (Intermezzo) only (must meet all):
    a. Failure of trials of 2 preferred sedative, hypnotic agents (eszopiclone, temazepam 15 mg & 30 mg, and zolpidem) unless contraindicated or clinically significant adverse effects are experienced;
    b. Documentation of middle of the night awakenings;
    c. Dose does not exceed 1.75mg/day for women, and 3.5mg/day for men;
5. For Edluar only: Documentation of inability to swallow pills;
6. For all other Non-Preferred sedative, hypnotic agents: failure of trials of 2 preferred sedative, hypnotic agents (eszopiclone, temazepam 15 mg & 30 mg, and zolpidem) unless contraindicated or clinically significant adverse effects are experienced;
7. Dose does not exceed FDA max daily dosing. Refer to *Section V.* Dosage and Administration.

**Approval duration: 6 months**

**II. Continued Therapy**

**A. Insomnia** (must meet all)**:**

1. Currently receiving medication via a health plan affiliated with Centene Corporation or member has previously met initial approval criteria;
2. Member is responding positively to therapy (e.g., no significant toxicity);
3. If request is for a dose increase, new dose does not exceed FDA max approved daily dose. Refer to *Section V.* Dosage and Administration

**Approval duration: 12 months**

**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 – AZ.CP.PMN.53 for Arizona Medicaid.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration

*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 |
|---|---|---|
| eszopiclone (Lunesta) | 1 mg PO | 3 mg/day |
| temazepam (Restoril) | Adults: 15 - 30 mg PO Elderly: 7.5 - 15 mg PO | 30 mg/day |
| zolpidem (Ambien) | Adults: 5-10 mg PO<br>Elderly: 5 mg PO | 10 mg/day |
| doxepin Solution<br><br>doxepin Capsules | Adults: 3-6 mg<br>Elderly: 3 mg<br>Adults:10-50mg | 6mg/day |
| Rozerem (ramelteon) – BRAND only | 8 mg PO HS | 8 mg/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*

*See Individual Package Inserts*

*Appendix D: General Information*

- Because 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.
- Rozerem is a melatonin receptor agonist, Silenor is a histamine H1 receptor antagonist, and Belsomra and Dayvigo are orexin receptor antagonists. These agents do not work through the GABA-A receptors, as do the other available agents in this class.
- Silenor is not a scheduled controlled substance.
- Zolpidem has a Micromedex Class IIa indication for improving sleep in patients with SSRI induced insomnia. The insomnia had been ongoing for two weeks while on the SSRI.
- The recommended initial doses for women and men are different because zolpidem clearance is lower in women
- Intermezzo is not indicated when patient has fewer than 4 hours of bedtime before planned time of waking.

## V. Dosage and Administration

| Indication | Dosing Regimen | Maximum Dose |
|---|---|---|
| Belsomra (suvorexant) | 10 mg – 20 mg PO QHS | 20 mg/day |
| Dayvigo (lemborexant) | 5 mg PO taken QHS | 10 mg/day |
| estazolam (Prosom) | 1-2 mg QHS | 2 mg/day |
| eszopiclone (Lunesta) | Adults: 1-3 mg PO Q HS<br>Elderly: 1-2 mg PO Q HS | Adults: 3mg/day<br>Elderly: 2mg/day |
| flurazepam (Dalmane) | Adults: 15 - 30 mg PO QHS<br>Elderly: 15 mg PO QHS<br>Generally not recommended in the elderly due to long half-life of active metabolite | 30 mg/day |
| Rozerem (ramelteon) | Adults: 8 mg PO QHS | 8 mg/day |
| temazepam (Restoril) | 7.5 to 30 mg PO QHS | 30 mg/day |
| triazolam (Halcion) | Adults: 0.125 - 0.5 mg PO QHS | Adults: 0.5 mg/day<br>Elderly: 0.25 mg/day |
| zaleplon (Sonata) | Adults: 10 mg PO QHS<br>Elderly: 5 mg PO QHS | Adults: 20 mg/day<br>Elderly: 10 mg/day |

| Indication | Dosing Regimen | Maximum Dose |
|---|---|---|
| Silenor (doxepin) | Adults: 3-6 mg PO QHS | 6 mg/day |
| zolpidem (Ambien) | Adults: 5-10 mg PO<br>Elderly: 5 mg PO | 10 mg/day |
| zolpidem extended release (Ambien CR ) | Adults: 6.25-12.5 mg PO QHS | Elderly: 6.25 mg PO QHS |
| Zolpidem tartrate (Edluar) | Adults: 5 mg SL for women and 5-10 mg for men SL HS PRN<br>Elderly: 5 mg SL HS PRN | Adults: 10 mg/day<br>Elderly: 5 mg/day |
| Zolpidem tartrate (Intermezzo) | Women:<br>1.75 mg SL HS PRN<br>Men:<br>3.5 mg SL HS PRN<br>Elderly:<br>1.75 mg SL HS PRN | 3.5 mg/day |
| Zolpidem tartrate (Zolpimist) | Adults: 5 mg for women and 5 or 10 mg for men PO HS PRN immediately before bedtime<br>Elderly: 5 mg PO HS PRN immediately before bedtime | Adults: women – 5 mg/day, men – 10 mg/day<br>Elderly: 5 mg/day |

## VI. Product Availability

| Drug Name | Availability |
|---|---|
| Edluar (zolpidem SL tablets) | Sublingual tablets: 5 mg, 10 mg |
| Estazolam (Prosom) | Tablets: 1 mg, 2 mg |
| Eszopiclone (Lunesta) | Tablets: 1 mg, 2 mg, 3 mg |
| Flurazepam (Dalmane) | Capsules: 15 mg, 30 mg |
| zolpidem SL tablets (Intermezzo) | Sublingual tablets: 1.75 mg, 3.5 mg |
| Zolpimist (zolpidem oral spray) | Oral spray: 5 mg per actuation |
| Rozerem (ramelteon) | Tablets: 8 mg |
| Silenor (doxepin) | Tablets: 3 mg, 6 mg |
| Triazolam (Halcion) | Tablets: 0.125 mg, 0.25 mg |
| Belsomra (suvorexant) | Tablets: 5 mg, 10 mg, 15 mg, 20 mg |

| Drug Name | Availability |
|---|---|
| Dayvigo (lemborexant) | Tablets: 5 mg, 10 mg |
| Zolpidem CR | Tablets: 6.25 mg, 12.5 mg |
| Zaleplon (Sonata) | Capsules: 5 mg, 10mg |

## VII. References

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| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|---|---|
| Converted to new template; annual review, no significant changes; Addition of other non-benzodiazepine insomnia agents (Edular, Intermezzo, Rozerem, Silenor, Zolpidem CR, Zolpimist) to criteria. | 03.18 | 04.18 |
| Added estazolam, flurazepam, triazolam, Silenor, eszopiclone, zaleplon to the PA required list under "Description" and updated medications in "Therapeutic Alternatives" based on AHCCCS drug list. Changed name from "Non-benzodiazepine" to "Non-preferred" | 05.18 | 07.18 |
| Changed name from "Non-preferred Agents for Insomnia" to "Agents for Insomnia", since Rozerem is preferred but require prior authorization; Added max dose for Intermezzo | 04.19 | 07.19 |
| Added criteria for eszopiclone and Edluar; Updated criteria for all other Non-Preferred sedative, hypnotic agents: failure of a trial of 2 preferred sedative, hypnotic agents (eszopiclone, Rozerem, temazepam, and zolpidem);Updated Appendix C, Section V, and Section VI; Renumber to AZ.CP.PMN.1016; Added section for AHCCCS preferred products. | 12.19 | 01.20 |
| Added Dayvigo to the AHCCCS non-preferred drugs and detailed dosing. | 04.20 | 04.20 |
| 4Q 2020 P&T committee. Added clarification for step therapy for Rozerem- trial of 2 preferred products. References updated. | 10.20 | 11.20 |
| Added Care1st logo. Added verbiage to specify that criteria also applies to Care1st. | 5.10.21 | 04.21 |
| 4Q 2021 annual review: no significant changes; references reviewed and updated. | 10.30.21 | 11.21 |

**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.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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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.
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