

## Pharmacy Policy Bulletin

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**Title:** Sleep Agents

**Policy #:** Rx.01.84

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***Application of pharmacy policy is determined by benefits and contracts. Benefits may vary based on product line, group, or contract. Some medications may be subject to precertification, age, quantity, or formulary restrictions (ie limits on non-preferred drugs). Individual member benefits must be verified.***

***This pharmacy policy document describes the status of pharmaceutical information and/or technology at the time the document was developed. Since that time, new information relating to drug efficacy, interactions, contraindications, dosage, administration routes, safety, or FDA approval may have changed. This Pharmacy Policy will be regularly updated as scientific and medical literature becomes available. This information may include new FDA-approved indications, withdrawals, or other FDA alerts. This type of information is relevant not only when considering whether this policy should be updated, but also when applying it to current requests for coverage.***

***Members are advised to use participating pharmacies in order to receive the highest level of benefits.***

### ▶ **Intent:**

The intent of this policy is to communicate the medical necessity criteria for **zolpidem tartrate (Ambien® and Ambien CR®), zolpidem (Intermezzo®, Zolpimist®), zolpidem tartrate sublingual tablets (Edluar®), and tasimelteon (Hetlioz®)** as provided under the member's prescription drug benefit.

### ▶ **Description:**

Insomnia is one of the most common medical complaints, generating more than 5 million office visits per year in the United States. Typical complaints include difficulty falling asleep, staying asleep, and variable sleep. Insomnia is present when all of the following criteria are met:

- A. A complaint of difficulty initiating sleep, difficulty maintaining sleep, or waking up too early. In children or individuals with dementia, the sleep disturbance may manifest as resistance to going to bed at the appropriate time or difficulty in sleeping without caregiver assistance.
- B. The above sleep difficulty occurs despite adequate opportunity and circumstances for sleep.
- C. The impaired sleep produces deficits in daytime function.

Insomnia is classified as short-term, long-term, or other depending upon the duration and causes.

Non-24-hour sleep-wake rhythm disorder is characterized by failure of the circadian system to maintain stable alignment (called "entrainment") to the 24-hour day. As a result, the circadian system "free runs" and typically shifts to progressively later phase positions. The most common cause is blindness, as the daily light-dark cycle is the most powerful environmental cue for synchronizing the hypothalamic pacemaker to the 24-hour day.

Zolpidem tartrate (Ambien® and Ambien CR®) is a nonbenzodiazepine hypnotic that is indicated in the treatment of individuals who have insomnia characterized by difficulties with sleep onset and/or sleep maintenance.

Zolpidem tartrate (Edluar®) and (Zolpimist®) are nonbenzodiazepine hypnotics indicated for the treatment of insomnia characterized by difficulties with sleep initiation.

Zolpidem tartrate sublingual tablet (Intermezzo®) is indicated for the treatment of insomnia when a middle-of-the-night awakening is followed by difficulty returning to sleep.

Zolpidem tartrate (Ambien® and Ambien CR®), zolpidem (Zolpimist®), zolpidem tartrate sublingual tablet (Intermezzo®) and zolpidem sublingual tablets (Edluar®) exert a hypnotic effect by binding to the alpha-1 subunit of GABA receptors.

Tasimelteon (Hetlioz®) is indicated for the treatment of non-24-hour sleep-wake disorder (non-24).

Tasimelteon (Hetlioz®) is an agonist of melatonin receptors MT<sub>1</sub> and MT<sub>2</sub> (greater affinity for the MT<sub>2</sub> receptor than the MT<sub>1</sub> receptor). Activation of MT<sub>1</sub> is thought to preferentially induce sleepiness, while MT<sub>2</sub> receptor activation preferentially influences regulation of circadian rhythms.

#### Policy:

Edluar® 5mg, Zolpimist®, Intermezzo® 1.75mg are approved when documentation is provided of ALL of the following:

1. Diagnosis of insomnia; and
2. One of the following:
  - a. Inadequate response or inability to tolerate TWO of the following:
    - i. Eszopiclone
    - ii. Zaleplon
    - iii. Zolpidem

OR

- b. Inability to swallow capsules/tablets (eg, dysphagia, gastrointestinal [GI] tubes)

Any of the following high dose products (brand and generic): zolpidem tartrate (Ambien®) 10mg, zolpidem tartrate ER (Ambien® CR) 12.5mg, zolpidem tartrate SL (Intermezzo®) 3.5mg, eszopiclone (Lunesta®) 3mg and Edluar® 10mg are approved when there is documentation of ALL of the following:

1. Diagnosis of insomnia; and

2. Patient has been counseled on practices associated with good sleep hygiene (e.g. avoiding stimulants such as caffeine, nicotine, alcohol close to bed time, etc.); and
3. Titration history (as recommended by dosing guidelines for individual product) demonstrating an appropriate trial of the lower dose of the requested product; and
4. Inadequate response to a two-week trial of the lower dose
5. Inadequate response or inability to tolerate a generic equivalent (applies to BRANDS with generic equivalents only)

Tasimelteon (Hetlioz®) is approved when ALL of the following inclusion criteria are met:

1. Member is 18 years of age or older; and
2. Member is totally blind; and
3. Diagnosis of a circadian period greater than 24 hours by a sleep specialist; and
4. Inadequate response or inability to tolerate ramelteon (Rozerem®)

#### ▸ **Black Box Warning:**

None

#### ▸ **Guidelines:**

Refer to the specific manufacturer's prescribing information for administration and dosage details and any applicable Black Box warnings.

### **BENEFIT APPLICATION**

Subject to the terms and conditions of the applicable benefit contract, the applicable drug(s) identified in this policy is (are) covered under the prescription drug benefits of the Company's products when the medical necessity criteria listed in this pharmacy policy are met. Any services that are experimental/investigational or cosmetic are benefit contract exclusions for all products of the Company.

#### ▸ **References:**

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➤ **Applicable Drugs:**

 Inclusion of a drug in this table does not imply coverage. Eligibility, benefits, limitations, exclusions, precertification/referral requirements, provider contracts, and Company policies apply.

Brand Name	Generic Name
Ambien® [CR]	zolpidem tartrate immediate and extended release (PA applies to generic 10mg IR and 12.5mg CR)
Edluar®	zolpidem sublingual tablets
Zolpimist®	zolpidem
Intermezzo®	zolpidem
Hetlioz®	tasimelton

 **Cross References:**

N/A

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<b>Policy Version Number:</b>	12.00
<b>P&amp;T Approval Date:</b>	July 12, 2018
<b>Policy Effective Date:</b>	October 01, 2018
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The Policy Bulletins on this web site were developed to assist the Company in administering the provisions of the respective benefit programs, and do not constitute a contract. If you have coverage through the Company, please refer to your specific benefit program for the terms, conditions, limitations and exclusions of your coverage. Company does not provide health care services, medical advice or treatment, or guarantee the outcome or results of any medical services/treatments. The facility and professional providers are responsible for providing medical advice and treatment. Facility and professional providers are independent contractors and are not employees or agents of the Company. If you have a specific medical condition, please consult with your doctor. The Company reserves the right at any time to change or update its Policy Bulletins.