

Document ID#: 2111794
Subject: Insomnia Treatments
Effective Date: November 9, 2010

Clinical Documentation and Prior Authorization Required	√	Type of Review — Case Management	
Not Covered		Type of Review — Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Administrative Process (Internal Use Only)	LPN

Note: This pharmacy medical necessity guideline applies to commercial products. For Tufts Health Plan Medicare Preferred members, please refer to the Tufts Medicare Preferred Step Therapy Criteria. Background, applicable product and disclaimer information can be found on the last page.

Overview

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 used as a hypnotic agent for the short-term management of insomnia, generally for periods not exceeding 7-10 days in duration. Because of its short half-life, zolpidem tartrate may be of particular benefit for the initiation of sleep (e.g. decreasing sleep latency). In controlled clinical trials, zolpidem tartrate reportedly has been effective in decreasing sleep latency and prolonging total sleep time for periods up to 35 days in duration.

Lunesta® (eszopiclone) is approved as a hypnotic agent for the management of transient and chronic insomnia. In controlled clinical studies, eszopiclone reportedly has been shown to have continued efficacy in decreasing sleep latency and prolonging total sleep time when administered nightly for periods up to 6 months in duration.

Rozerem™ (ramelteon) is indicated for the management of insomnia characterized by difficulty with sleep onset. In one clinical trial, sleep latency was reduced by up to 39% with ramelteon vs. placebo. There is no evidence showing potential for abuse or dependence with ramelteon.

Sonata® (zaleplon) is used in the short-term management of insomnia. Zaleplon has been shown to decrease sleep latency with repeated use for periods up to 30 days in duration. Because of the drug's short half-life, clinical studies have focused on decreasing sleep latency. The drug has not been shown to substantially increase total sleep time or decrease the number of awakenings, and therefore appears to be most useful for sleep initiation disorders.

Pharmacy Coverage Guidelines

Note: Prescriptions that meet the initial step therapy requirements, will adjudicate at the point of service. If the Member does not meet the initial step therapy criteria, the prescription will be denied at the point of service with a message indicating that prior authorization (PA) is required. Refer to the Coverage Criteria below and submit prior authorization requests to Tufts Health Plan using the Universal Pharmacy Medical Review Request Form for Members who do not meet the step therapy criteria at the point of service.

Please refer to the table below for formularies and medications subject to this policy:

Drug	Tufts Health Plan Commercial Massachusetts Formulary	Tufts Health Plan Generic Focused Formulary	Tufts Health Plan Commercial R.I. Formulary
Step-1			
zaleplon	Covered	Covered	Covered
zolpidem tartrate			
Step-2			
Lunesta®	Requires prior use of a drug on Step-1	Requires prior use of a drug on Step-1	Requires prior use of a drug on Step-1
Rozerem™			
zolpidem tartrate CR			
Not Covered (Step-3)			
Ambien®	Not Covered	Not Covered	Not Covered
Ambien CR™			
Edluar®			
Sonata®			

Automated Step Therapy Coverage Criteria

Step 1: Medications on Step-1 are covered without prior authorization

Step 2: Tufts Health Plan may cover Step 2 medications if the following criteria are met:

- The member has had a 30-day trial of a Step-1 or Step-2 medication within the previous 180 days as evidenced by a previous paid claim under the prescription benefit administered by Tufts Health Plan.

Coverage Criteria for Members not meeting the Automated Step Therapy Coverage Criteria at the Point of Sale

The following stepped approach applies to insomnia treatments covered by Tufts Health Plan:

Step 2: Tufts Health Plan may cover medications on Step-2 if the following criteria are met:

- The Member has had previous trial of Step-1, Step-2, or Step-3 insomnia treatment drug as evidenced by physician documented use within the previous 2 years, excluding the use of samples
- OR**
- The Member has a physician documented contraindication or intolerance to zaleplon and zolpidem.

Not Covered (Step 3): Tufts Health Plan may cover drugs on Step-3 if the following criteria are met:

- A formulary exception request is submitted and approved by Tufts Health Plan for non-covered drugs. Please refer to the Pharmacy Medical Necessity Guidelines for Non-Covered Drugs.
- AND**
- The Member has had previous trial of Step-1, Step-2, or Step-3 insomnia treatment drug within the previous 180 days as evidenced by paid claims under the prescription benefit administered by Tufts Health Plan or within the last 2 years by physician documented use, excluding the use of samples.

Note: Formulary exception requests that meet the step therapy guidelines and are approved by Tufts Health Plan will adjudicate at the highest co-pay tier based on the Members pharmacy benefit.

Limitations

1. Medications on Step-2 or Step-3 are not covered unless the above step therapy criteria are met.
2. The following quantity limitations apply to any strength and combination of zaleplon, zolpidem tartrate, zolpidem tartrate CR, Ambien, Ambien CR, Edluar, Lunesta, Rozerem and/or Sonata:
 - At retail pharmacy - 10 capsules/tablets per 30 days
 - At mail order pharmacy - 30 capsules/tablets per 90 days

Please refer to the Pharmacy Medical Necessity Guidelines for Drugs with Quantity Limitations and submit a formulary exception request for those Members requiring higher quantities.

For Tufts Health Plan Medicare Preferred MA-PD and PDP Members, please refer to the Comprehensive Formulary listing on the Web for individual quantity limitations.

3. Exception requests for additional quantities of the drugs included in this program may be authorized in 12-month intervals.

Codes

None.

References

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11. Mack A, Salazar JO. Eszopiclone: a novel cyclopyrrolone with potential benefit in both transient and chronic insomnia. *Formulary*. 2003; 38:582-93.
12. Rozerem™ (ramelteon) [package insert]. Deerfield, IL: Takeda Pharmaceuticals America, Inc.; April 2006.
13. Sonata® (zaleplon) [package insert]. Philadelphia, PA: Wyeth Pharmaceuticals Inc.; March 2006.
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15. Walsh JK, Fry J, Erwin CW et al. Efficacy and tolerability of 14-day administration of zaleplon 5mg and 10mg for the treatment of primary insomnia. *Clin Drug Invest*. 1998; 16:347-54.
16. Edluar® (zolpidem tartrate) [package insert]. Sweden: Orexo AB; March 2009.

Approval History

Reviewed by the Pharmacy and Therapeutics Committee on May 8, 2007.

Subsequent Endorsement Date(s) and Changes Made:

1. November 13, 2007: Added Tufts Health Plan Commercial Formulary to Step Therapy Program.
2. May 13, 2008:
 - Added zaleplon to Step-1 of step therapy program
 - Added dispensing limitation for zaleplon
 - Moved Sonata to Non-covered status for the Generic Focused Formulary
3. July 8, 2008:
 - Added limitation that exception requests for additional quantities of the drugs listed above may be authorized in 12-month intervals.
 - Added dispensing limitations of 30 capsules/tablets per 90 days at mail to all drugs included in this step therapy program.
4. March 10, 2009:
 - Moved Sonata to Non-covered status for Tufts Health Plan Commercial and R.I. formularies.
5. September 8, 2009:

- Added Edluar (zolpidem tartrate) to criteria on non-covered status.
 - Added Insomnia Treatments step therapy program to Tufts Health Plan Medicare Preferred MA-PD and PDP formularies.
 - Added note to limitations for Tufts Health Plan Medicare Preferred MA-PD and PDP Members to refer to the Comprehensive Formulary listing on the Web for individual quantity limitations.
6. January 1, 2010:
 - Removal of Tufts Medicare Preferred language (separate criteria have been created specifically for Tufts Medicare Preferred).
 7. September 14, 2010: No changes.
 8. November 9, 2010:
 - Added zolpidem tartrate CR to Step-2 of the Insomnia Treatment Medical Necessity Guidelines.
 - Added zolpidem tartrate CR to the limitations with the QL of 10 tablets per 30 days.
 9. Removed the word “Dispensing” from the Pharmacy Medical Necessity Guidelines for Drugs with Dispensing Limitations, and replaced it with “Quantity”.
 10. September 9, 2011: Added historical look back period of 2 years for physician documented use of Step Therapy pre-requisite drugs.

Background, Product and Disclaimer Information

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for Tufts Health 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). Tufts Health 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 Tufts Health Plan 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 revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Pharmacy Medical Necessity Guidelines apply to all fully insured Tufts Health Plan offerings unless otherwise noted in this policy or the Member’s benefit document. Check the applicable formulary in the Pharmacy section of our Website at www.tuftshealthplan.com to determine if the drug requires you to get prior authorization. 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 CareLinkSM 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 Medicare Preferred, please refer to Tufts Medicare Preferred Step Therapy 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.

