Clinical Policy: Zolpidem Tartrate (Edluar, Intermezzo, Zolpimist)

Reference Number: DE.PMN.172
Effective Date: 01.23
Last Review Date: 01.23
Line of Business: Medicaid

Revision Log

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

Description

Zolpidem tartrate (Edluar®, Intermezzo®, Zolpimist®) is a gamma-aminobutyric acid ($GABA_A$) agonist.

FDA Approved Indication(s)

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

Intermezzo is indicated for use as needed for the 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.

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 health plans affiliated with Centene Corporation® that Edluar, Intermezzo, and Zolpimist are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Diagnosis of insomnia;
2. Age ≥ 18 years;
3. Failure of an adequate trial of at least two preferred* FDA-approved drugs for the indication and/or drugs that are considered the standard of care within the same drug class on the PDL, when such agents exist, at maximum indicated doses, unless clinically significant adverse effect are experienced, or all are contraindicated;
   ** Generic is preferred, if available, and brand is not the preferred agent*;
4. Dose does not exceed (a or b):
   a. Edluar, Zolpimist: 10 mg per day;
   b. Intermezzo: 3.5 mg per day.

Approval duration:
Medicaid – 6 months

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53.

II. Continued Therapy

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

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. For brand Intermezzo requests, member must use generic zolpidem sublingual tablet 1.75 mg or 3.5 mg, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, new dose does not exceed (a or b):
   a. Edluar, Zolpimist: 10 mg per day;
   b. Intermezzo: 3.5 mg per day.

Approval duration:
Medicaid – 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53.

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 – CP.PMN.53 or evidence of coverage documents.

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
zolpidem tartrate (Ambien®)	Adults: 5-10 mg PO HS PRN Elderly: 5 mg PO HS PRN	10 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

- Contraindication(s): known hypersensitivity to zolpidem
- Boxed warning(s): none reported

V. Dosage and Administration

Drug Name	Dosing Regimen	Maximum Dose
Zolpidem tartrate (Edluar)	Adults: 5 mg SL for women and 5-10 mg for men SL HS PRN Elderly: 5 mg SL HS PRN	Adults: 10 mg/day Elderly: 5 mg/day
Zolpidem tartrate (Intermezzo)	Women: 1.75 mg SL HS PRN Men: 3.5 mg SL HS PRN Elderly: 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 Elderly: 5 mg PO HS PRN immediately before bedtime	Adults: women – 5 mg/day, men – 10 mg/day Elderly: 5 mg/day

VI. Product Availability

Drug Name	Availability
Zolpidem tartrate (Edluar)	Sublingual tablets: 5 mg, 10 mg
Zolpidem tartrate (Intermezzo)	Sublingual tablets: 1.75 mg, 3.5 mg
Zolpidem tartrate (Zolpimist)	Oral spray: 5 mg per actuation

VII. References

1. Edluar Prescribing information. Bridgewater, NJ: Sanofi-Aventis; August 2019. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/021997s010lbl.pdf. Accessed July 5, 2022.
2. Intermezzo Prescribing Information. Stamford, CT: Purdue Pharma LP; August 2019. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/022328s007lbl.pdf. Accessed July 5, 2022.
3. Zolpimist Prescribing Information. Louisville, KY: MAGNA; August 2019. Available at: https://myzolpimist.com/ . Accessed July 5, 2022.
4. Sateia MJ, Buysse DJ, Krystal AD, Neubauer DN, Heald JL. Clinical practice guideline for the pharmacologic treatment of chronic insomnia in adults: an American Academy of Sleep Medicine clinical practice guideline. J Clin Sleep Med. 2017;13(2):307–349.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	11.22	01.23

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.