

GENERIC STEP THERAPY PLANS (GSTP)

DRUG CLASS

INSOMNIA AGENTS

PGST SSB – Ref# 372-D: Edluar, Rozerem, Zolpimist

HPGST SSB – Ref# 406-D: Belsomra, Edluar, Rozerem, Silenor, Zolpimist

TGST SSB – Ref# 382-D: Belsomra, Edluar, Rozerem, Silenor, Zolpimist

Status: CVS Caremark Criteria

Type: Initial Step Therapy; Post Step Therapy Prior Authorization

INITIAL STEP THERAPY

If the patient has filled a prescription for at least a 30 day supply of a generic non-benzodiazepine hypnotic within the past 180 days under a prescription benefit administered by CVS Caremark, then the requested branded drug will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the system will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

COVERAGE CRITERIA

Branded insomnia agents will be covered with post step therapy prior authorization when the following criteria are met:

- Patient has experienced an inadequate treatment response, intolerance, contraindication or potential drug interaction to at least one generic non-benzodiazepine hypnotic drug.

RATIONALE

If the patient has filled a prescription for a least a 30 day supply of a generic non-benzodiazepine hypnotic within the past 180 days under a prescription benefit administered by CVS Caremark, then the requested branded drug will be paid under that prescription benefit.

If the patient does not meet the initial step therapy criteria, then prior authorization is required.

If the patient has a documented contraindication to or a potential drug interaction with a generic drug, then the requested brand drug will be covered. If the patient is intolerant to at least one of the generic drugs, then the requested brand drug will be covered. If the patient has tried one of the generic drugs for at least 30 days and had an inadequate treatment response, then the requested brand drug will be covered. If these requirements are met, then the approval duration is 24 months.

REFERENCES

N/A

Written by: UM Development (NB)

Date Written: 04/2009

Revised: 10/2009, 01/2010, 04/2010, 06/2010, 10/2010, 12/2010, 01/2011, 05/2011, 09/2011, 12/2011, 09/2012 (updated formatting and documentation), 10/2012 (removed documentation), 11/2012, 11/2013 (reworded question #2, streamlined order of questions), 04/2014 (removed Lunesta from HPGST & TGST), 08/2014 (removed Lunesta from PGST), 11/2014, 07/2015 (added Belsomra to target list for HPGST & TGST), 08/2015 (added Belsomra to PGST), 11/2015, 04/2016 (removed Intermezzo), 11/2016 (no changes); (SF) 11/2017 (removed Belsomra from PGST), 10/2018 (no changes)

Reviewed: Medical Affairs (KP) 05/2009, 10/2009, 01/2010, 06/2010, 10/2010, 12/2010, 01/2011, 09/2011, 12/2011; (DC) 09/2012, 11/2012, (LS) 11/2013, (DC) 08/2014, (DC) 11/2014

External Review: 05/2009, 12/2009, 02/2010, 04/2010, 08/2010, 02/2011, 08/2011, 01/2012, 04/2013, 04/2014, 02/2015, 02/2016, 02/2017, 02/2018, 02/2019

GSTP Insomnia Agents COMM 10-2018

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CRITERIA FOR APPROVAL

1	Has the patient demonstrated an inadequate treatment response after at least a 30 day trial of a generic insomnia drug? [If yes, then no further questions.]	Yes	No
2	Does the patient have a documented contraindication to or a potential drug interaction with a generic insomnia drug? [If yes, then no further questions.]	Yes	No
3	Has the patient had a trial and was intolerant to at least one generic insomnia drug?	Yes	No

Guidelines for Approval

Duration of Approval				24 Months	
Set 1 - Failed Trial		Set 2 – Contraindication		Set 3 – Intolerance	
Yes to question(s)	No to question(s)	Yes to question(s)	No to question(s)	Yes to question(s)	No to question(s)
1	None	2	1	3	1
					2

Mapping Instructions

	Yes	No
1	Approve for 24 months	Go to 2
2	Approve for 24 months	Go to 3
3	Approve for 24 months	Deny