# 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, or contraindication 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) |
| 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 |

## CRITERIA FOR APPROVAL

| | | | |
|---|---|---|---|
| 1 | Has the patient demonstrated an inadequate treatment response after at least a 30 day trial of a generic insomnia drug?<br>[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?<br>[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 |