Clinical Policy: Zolpidem Tartrate (Edluar, Intermezzo, Zolpimist)
Reference Number: CP.PMN.172
Effective Date: 12.01.18
Last Review Date: 11.20
Line of Business: Commercial, Medicaid

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_\text{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\textsuperscript{\textregistered} 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 \geq 18 years;
      3. For Edluar and Zolpimist: Failure of zolpidem oral tablets, unless contraindicated or clinically significant adverse effects are experienced;
      4. For Intermezzo: Member has a history of insomnia with difficulty returning to sleep after middle of the night awakening;
      5. 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
Commercial – Length of Benefit
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.CPA.09 for commercial and CP.PMN.53 for Medicaid.

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. 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
   Commercial – Length of Benefit

   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.CPA.09 for commercial and CP.PMN.53 for Medicaid.

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.CPA.09 for commercial and CP.PMN.53 for Medicaid 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.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>zolpidem tartrate</td>
<td>Adults: 5-10 mg PO HS PRN</td>
<td>10 mg/day</td>
</tr>
<tr>
<td>(Ambien®)</td>
<td>Elderly: 5 mg PO HS PRN</td>
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</table>

   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

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<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
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</thead>
<tbody>
<tr>
<td>Zolpidem tartrate (Edluar)</td>
<td>Adults: 5 mg SL for women and 5-10 mg for men SL HS PRN</td>
<td>Adults: 10 mg/day</td>
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<tr>
<td></td>
<td>Elderly: 5 mg SL HS PRN</td>
<td>Elderly: 5 mg/day</td>
</tr>
<tr>
<td>Zolpidem tartrate (Intermezzo)</td>
<td>Women: 1.75 mg SL HS PRN</td>
<td>3.5 mg/day</td>
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<tr>
<td></td>
<td>Men: 3.5 mg SL HS PRN</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elderly: 1.75 mg SL HS PRN</td>
<td></td>
</tr>
<tr>
<td>Zolpidem tartrate (Zolpimist)</td>
<td>Adults: 5 mg for women and 5 or 10 mg for men PO HS PRN immediately before bedtime</td>
<td>Adults: women – 5 mg/day, men – 10 mg/day</td>
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<tr>
<td></td>
<td>Elderly: 5 mg PO HS PRN immediately before bedtime</td>
<td>Elderly: 5 mg/day</td>
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VI. Product Availability

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Availability</th>
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<tbody>
<tr>
<td>Zolpidem tartrate (Edluar)</td>
<td>Sublingual tablets: 5 mg, 10 mg</td>
</tr>
<tr>
<td>Zolpidem tartrate (Intermezzo)</td>
<td>Sublingual tablets: 1.75 mg, 3.5 mg</td>
</tr>
<tr>
<td>Zolpidem tartrate (Zolpimist)</td>
<td>Oral spray: 5 mg per actuation</td>
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VII. References


Reviews, Revisions, and Approvals

<table>
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<tr>
<th>New policy created: policy split from and retired CP.CPA.265 non-benzodiazepine insomnia medications; added Medicaid line of business; added age limit; references reviewed and updated.</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tbody>
<tr>
<td></td>
<td>07.31.18</td>
<td>11.18</td>
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Reviews, Revisions, and Approvals

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<th>Date</th>
<th>P&amp;T Approval Date</th>
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<td>08.27.19</td>
<td>11.19</td>
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<td>08.21.20</td>
<td>11.20</td>
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**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.

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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.

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