Pharmacy

Step Therapy/Prior Authorization Criteria for Newer Sedative Hypnotics

Background

Ambien (zolpidem immediate release) is DoD's preferred Uniform Formulary agent in this class and is the sole agent designated Basic Core Formulary. It has a long record of safety and efficacy. Sonata (zaleplon), Ambien CR, Lunesta, Intermezzo, Silenor, and Hetlioz are also on the Uniform Formulary, while Rozerem, Edluar and Zolpimist are non-formulary under the Uniform Formulary.

In order to promote use of zolpidem immediate release or Sonata, the step-preferred agents, step therapy/prior authorization requirements apply to Ambien CR, Intermezzo, Lunesta, Silenor, Rozerem, Zolpimist, Edluar, and Hetlioz. TRICARE coverage of these agents depends on whether you meet step therapy/prior authorization criteria.

What is Step Therapy?

Step therapy involves prescribing a safe, cost effective medication as the first step in treating a medical condition. The preferred medication is often a generic mediation that offers the best overall value in terms of safety, effectiveness, and cost. Non-preferred drugs are only prescribed if the generic is ineffective or poorly tolerated.

Ambien CR, Lunesta, Silenor, Rozerem, Intermezzo, Zolpimist , Edluar, and Hetlioz will only be approved for first time users after they have tried generic zolpidem IR or Sonata.

Prior Authorization Criteria for Hetlioz

PA criteria apply to all new users of **Hetlioz**

Automated PA criteria: The patient has filled a prescription for zolpidem IR or zaleplon at any MHS pharmacy POS (MTFs, retail network pharmacies, or mail order) during the previous 180 days.

AND

Manual PA criteria: If automated criteria are not met, tasimelteon (Hetlioz) is approved (e.g., trial of zolpidem immediate release or zaleplon is NOT required) if the patient meets criterion #1 below, and one of the other criteria (#2, #3, or #4).

1) The patient is totally blind and has no light perception AND
2) The patient has received a trial of zolpidem IR or zaleplon and had an inadequate response OR
3) The patient received a trial of zolpidem IR or zaleplon but was unable to tolerate it due to adverse effects OR
4) Treatment with zolpidem IR or zaleplon is contraindicated for this patient (e.g., due to hypersensitivity, aberrant behaviors, or intolerable rebound insomnia)

Manual Prior Authorization Criteria for for Ambien CR (zolpidem extended release), Lunesta (eszopiclone), Silenor (doxepin), Rozerem (ramelteon), Hetlioz (tasimeltion),

Intermezzo or Zolpimist (zolpidem), Edluar (zolpidem sublingual)

Manual PA criteria:

1. The patient has an inadequate response to, been unable to tolerate due to adverse effects, or has a contraindication to zolpidem IR or zaleplon (e.g., hypersensitivity, aberrant behaviors, or intolerable rebound insomnia).
2. For Edluar, Zolpimist or Intermezzo the patient is unable to swallow or has swallowing difficulties.
3. For Rozerem or Silenor the patient requires a non-controlled agent due to potential for abuse.

Criteria approved through the DOD P&T Committee process August 2014

US Family Health Plan Newer Sedative Hypnotics Prior Authorization Request Form

for **Ambien CR / zolpidem ER** tablet, **Edluar** (zolpidem sublingual tablet), **Hetlioz** (tasimelteon), **Intermezzo** (zolpidem sublingual tablet), **Lunesta** (eszopiclone), **Rozerem** (ramelteon), **Silenor** (doxepin), **Zolpimist** (zolpidem oral spray)

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To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan pharmacy program (USFHP).

MAIL ORDER and RETAIL	• The provider may **call**: **1-877-880-7007** or the completed form may be **faxed** to:**1-617-562-5296** • The patient may attach the completed form to the prescription and mail it to: ATTN: Pharmacy, 77 Warren St, Brighton, MA 02135

Prior authorization criteria and a copy of this form are available at: http://usfamilyhealth.org/for-providers/downloadable-forms.
This prior authorization has no expiration date.

Step 1

Please complete patient and physician information (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2

Please complete the clinical assessment:

1. Is this a request for Hetlioz **?**	☐ Yes Proceed to question 2	☐ No **SKIP** to question **3**
2. *(Hetlioz request)* **Is the patient totally blind and has no light perception?**	☐ Yes Proceed to question 3	☐ No **STOP** Coverage not approved
3. Has the patient tried zolpidem immediate-release (IR) oral tablet or zaleplon and had an inadequate response or was unable to tolerate it due to adverse effects?	☐ Yes Sign and date below	☐ No Proceed to question 4
4. Is treatment with zolpidem IR oral tablet or zaleplon contraindicated for this patient, for example, due to hypersensitivity, aberrant behaviors, or intolerable rebound insomnia?	☐ Yes Sign and date below	☐ No Proceed to question 5

5. Which medication is requested?	☐ Ambien CR / zolpidem ER – **STOP**: **Coverage not approved**
	☐ Edluar, Intermezzo, Zolpimist – Proceed to question **6**
	☐ Hetlioz – **STOP**: **Coverage not approved**
	☐ Lunesta / eszopiclone – **STOP**: **Coverage not approved**
	☐ Rozerem, Silenor – Proceed to question **7**

6. *(Edluar, Intermezzo, Zolpimist request)* **Does the patient have swallowing difficulties?**	☐ Yes Sign and date below	☐ No Coverage not approved
7. *(Rozerem, Silenor request)* **Is the requested medication the most clinically suitable choice for this patient due to its apparent lack of abuse potential?**	☐ Yes Sign and date below	☐ No Coverage not approved

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

_____ _____

Prescriber Signature Date

[10 December 2014]