

Clinical Policy Title:	Lemborexant
Policy Number:	RxA.622
Drug(s) Applied:	Dayvigo®
Original Policy Date:	05/07/2020
Last Review Date:	05/07/2020
Line of Business Policy Applies to:	Commercial, Medicaid

Background

DAYVIGO is an orexin receptor antagonist indicated for the treatment of adult patients with insomnia, characterized by difficulties with sleep onset and/or sleep maintenance.

Dosing Information

Drug Name	Indication	Dosing Regimen	Maximum Dose
Lemborexant (Dayvigo)	Treatment of adult patients with insomnia characterized by difficulties with sleep onset and/or sleep maintenance	5mg taken no more than once per night Dosage may be increased to 10mg based on clinical response and tolerability	10mg daily

Dosage Forms

- Tablets: 5mg and 10mg

Clinical Policy

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

I. Initial Approval Criteria

A. Insomnia

1. The member is ≥ 18 years of age
2. The member has failed at least one drug recommended by treatment guidelines for use in patients with insomnia characterized by difficulties with sleep onset and/or sleep maintenance (i.e. temazepam (Restoril), quazepam (Doral), triazolam (Halcion), zolpidem (Ambien), zaleplon (Sonata), ramelteon (Rozerem), doxepin (Silenor), eszopiclone (Lunesta), suvorexant (Belsomra)).
3. The dose does not exceed 10mg per day.

Approval Duration:

Commercial: 6 months

Medicaid: 6 months

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

II. Continued Therapy Approval

A. Insomnia

1. Currently receiving medication that has been authorized by RxAdvance or member has previously met initial approval criteria listed in this policy.
2. The member is responding positively to therapy.

Approval Duration:

Commercial: 12 months

Medicaid: 12 months

III. Appendices

APPENDIX A: Abbreviation/Acronym Key

None

APPENDIX B: Therapeutic Alternatives

temazepam (Restoril), quazepam (Doral), triazolam (Halcion), zolpidem (Ambien), zaleplon (Sonata), ramelteon (Rozerem), doxepin (Silenor), eszopiclone (Lunesta), suvorexant (Belsomra)

APPENDIX C: Contraindications/Boxed Warnings

- Contraindication(s):
 - Dayvigo is contraindicated in patients with narcolepsy
- Boxed Warning(s):
 - None

References

1. Dayvigo Prescribing Information. Woodcliff Lakes, NJ; Eisai Inc: December 2019. Available at www.dayvigo.com. Accessed April 13, 2020.
2. Sateia MJ, et al. Clinical Practice Guideline for the Pharmacologic Treatment of Chronic Insomnia in Adults: An American Academy of Sleep Medicine Clinical Practice. Journal of Clinical Sleep Medicine. 2017;13(2). doi: 10.5664/jcsm.6470
3. Qaseem A, et al. Management of Chronic Insomnia Disorder in Adults: A Clinical Practice Guideline From the American College of Physicians. Annals of Internal Medicine. 2016;165(2):125-133. doi: 10.7326/M15-2175

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	05/07/2020	05/21/2020