

Wyoming Drug Utilization Review

A Brief Survey of Treatments for Insomnia

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Insomnia is defined as "...any of the following symptoms: difficulty falling asleep, waking a lot during the night, waking up too early and not being able to get back to sleep, and waking up feeling unrefreshed."¹ The National Sleep Foundation's 2002 Sleep in America Poll noted that 58% of adults reported experiencing at least one of the symptoms of insomnia at least a few nights during the week, and 35% of adults have experienced at least one of the symptoms almost every night for a year.¹ The prevalence of insomnia increases with age.²

Insomnia is classified into three categories, depending on symptom duration.³ *Transient insomnia* may be present for 2 to 3 days and is commonly associated with conditions such as jet

lag.³ *Short-term insomnia* lasts for 3 weeks or less and may be related to ongoing stresses.³ *Chronic or long-term insomnia* persists for over 3 weeks and is often associated with poor sleep hygiene, underlying psychological disorders, or substance abuse. Insomnia may also be classified as *sleep-onset insomnia*, which is associated with difficulty falling asleep, or *sleep-maintenance insomnia*, which occurs when a patient wakes during the night and cannot get back to sleep.

Treatment of insomnia may center on cognitive behavior therapy (CBT), medication, or a combination of both medication and CBT.⁴ Cognitive behavior therapy may consist of relaxation or educational interventions aimed at reducing sleep-onset insomnia. Recent research has suggested that CBT should be the treatment of choice for treating sleep-onset insomnia because CBT is at least as effective as pharmacotherapy, but does not have the adverse affects associated with many sleep medications.⁴ Despite recommen-

dations to use CBT for treatment of insomnia, use of medications remains the primary option for many physicians, especially for long-term management of insomnia.

Medications used to treat insomnia should cause the patient to fall asleep rapidly, and should allow the patient to stay asleep without altering sleep architecture or depressing respiration.⁵ Furthermore, the ideal sedative/hypnotic should not cause residual sedation or development of tolerance, should not interact with other CNS depressants, or cause rebound insomnia.⁵ Several drugs are currently available for treatment of insomnia. Some may be more effective or have fewer side effects than others. A brief summary of medications presently prescribed for insomnia follows.

Benzodiazepines are commonly used to alleviate insomnia.⁶ Benzodiazepines alter sleep architecture by prolonging stages 1 and 2 of sleep (light sleep) and suppressing the deep stages of sleep, stages 3 and 4, resulting in a less restful sleep.⁷ Despite concerns about untoward side effects and a lack of data demonstrating effectiveness for long-term use, benzodiazepines remain a treatment of choice by prescribers.⁸ In general, benzodiazepine use is associated with an increased incidence of dizziness, drowsiness, anterograde amnesia and motor and cognitive impairment.^{6,8} Short-acting benzodiazepines are more likely to cause rebound insomnia.⁹ Anterograde amnesia is a common consequence of triazolam consumption.¹⁰ Long-acting benzodiazepines are often associated with next-day sedation.⁹ Use of long-acting benzodiazepines in the elderly may cause an increased risk of falls, hip fractures, and poor cognitive function.⁹ Benzodiazepines should be used with caution in pregnancy as some studies have suggested they may pose an increased risk for birth defects.⁹

Unlike other insomnia drugs, eszopiclone (Lunesta®) has been approved by the FDA for treatment of both transient and chronic insomnia.¹¹ Eszopiclone's effects on sleep architecture are erratic and poorly understood, as effects on sleep stages 2 through 4 are highly variable.¹² Eszopiclone is appropriate for treating sleep-onset and sleep-maintenance insomnia.^{10,11,13} Eszopiclone is generally well-tolerated. The adverse effect most commonly described by patients using eszopiclone is an unpleasant, metallic taste, followed by headaches and residual sedation.¹³ Eszopiclone is rated as a pregnancy category "C" drug by the FDA, and should be used with caution during pregnancy.⁹

Ramelteon (Rozerem®) was recently approved by the FDA for treatment of insomnia. It is indicated primarily for sleep-onset insomnia.¹⁰ Ramelteon is unique among insomnia medications because it selectively binds to melatonin receptors in the brain's suprachiasmatic nucleus rather than GABA receptors.¹⁴ Ramelteon is well-tolerated, does not cause residual sedation and has a low abuse potential; headache is the most common adverse

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WY-DUR Board Meeting Update

The WY-DUR Board met for its bimonthly business meeting on January 25, 2007 in Cheyenne. Highlights of this meeting include:

- Medicaid drug coverage is now available on ePocrates. Instructions on accessing this information can be found on the WY-DUR website at www.uwyo.edu/DUR.
- Medicaid has been covering smoking cessation products since January 1, 2007 with a favorable response. Forty three clients had received smoking cessation medications as of the meeting date. Case management will be provided through APS Healthcare, Inc.
- Lovastatin will be added to the Medicaid Preferred Drug List for the statin class with no changes to the prior authorization criteria. Proposed implementation for this change is May 1, 2007.

- Pediatric patients will be required to obtain prior authorization for non-preferred proton pump inhibitors. Children under the age of 8 will not be required to obtain prior authorization for Prevacid. With this exception, the adult prior authorization criteria will be applied. This change will take effect on May 1, 2007.

The next meeting will be held March 29, 2007 in Laramie, Wyoming. Items for discussion will include prior authorization criteria for ADHD medications, tramadol and carisoprodol. An agenda will be available prior to the meeting on the WY-DUR website at www.uwyo.edu/DUR.

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effect associated with its use.^{15,16} Its low abuse potential makes ramelteon the only insomnia medication that is not considered a controlled substance by the FDA. Sleep architecture is not affected by the medication.¹⁴ Ramelteon is classified as a pregnancy category “C” drug by the FDA; caution should be exercised when prescribing for pregnant women.⁹

Zaleplon (Sonata®) is generally prescribed for short-term treatment of sleep-onset or sleep-maintenance insomnia.¹⁰ Zaleplon does not adversely affect sleep architecture.¹⁷ The most commonly reported adverse effect is headache. Researchers have demonstrated that the medication’s short half-life allows it to be administered nocturnally as little as 2 hours before waking up without residual sedation or cognitive or physical impairment.⁵ Zaleplon is classified as a pregnancy category “C” drug by the FDA.⁹

Zolpidem (Ambien® and Ambien® CR) is the most commonly prescribed sleep aid in the United States.⁹ Ambien® is prescribed primarily for sleep-onset insomnia;¹⁰ however, the new extended-release formulation of zolpidem, Ambien® CR, is indicated for sleep-onset and sleep-maintenance insomnia.¹⁸ Zolpidem is generally well-tolerated and does not appear to alter sleep architecture.¹² During long-term treatment, zolpidem resulted in more dizziness (reported by 5% of zolpidem patients) and “drugged” feelings (3%) than patients treated with placebo.¹⁹ Similar side effects were described for Ambien® CR.¹⁸ Zolpidem has recently been associated with cases of somnambulism and amnesic sleep-related eating disorders.²⁰ Ambien® is listed as a pregnancy category “B” drug by the FDA, and Ambien® CR is classified as a pregnancy category “C.”⁹

Patients should be counseled not to drive or operate heavy machinery after administration of any sedative/hypnotic drugs. Further, concurrent administration of insomnia medications with opiates, alcohol, or other CNS depressants should be avoided. Patients should also be advised to talk with their health care provider if they are taking a sleep medication concurrently with

potent CYP450 inducers or inhibitors because serum concentrations of the sedative/hypnotic may become dangerously elevated or sub-therapeutic, respectively.

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Final Criteria for Use of Antiepileptic Agents

WY-DUR Board 9/28/06

Claims will be approved for the following indications:

Gabapentin – epilepsy, neuropathic pain, and postherpetic neuralgia

Lamotrigine – epilepsy, bipolar disorder, and bipolar depressive disorder

Levetiracetam – epilepsy

Oxycarbazepine – epilepsy and bipolar disorder

Pregabalin – epilepsy, neuropathic pain secondary to diabetes with neurologic manifestations, and postherpetic neuralgia

Topiramate – epilepsy and migraine

Zonisamide – epilepsy

In addition, the following criteria will apply:

Pregabalin (Lyrica) – If diagnosis of neuropathic pain associated with diabetic peripheral neuropathy or postherpetic neuralgia, the patient must first fail treatment with gabapentin in the last 1 year.

Final Criteria for Use of Actiq and Fentora

WY-DUR Board 9/28/06

- Patient is at least 16 years old **AND**
- Patient has a cancer diagnosis or history of antineoplastics in the last thirty days **AND**
- Patient is tolerant to opioids as evidenced by history of at least 7 days therapy of a long-acting opioid (fentanyl patch, hydromorphone LA, morphine LA, or oxycodone LA) at a ceiling dose in the last thirty days

Thank you to those who provided feedback on these criteria.

Partnership for Prescription Assistance

Partnership for Prescription Assistance (PPA) helps qualifying patients who lack prescription coverage get the medicines they need through a public or private program. PPA offers a single point of access to more than 475 public and private patient assistance programs, including more than 150 programs offered by pharmaceutical companies. To find out more about PPA visit the PPA website at www.pparx.org or call toll free 1-888-477-2669.

Final Criteria for Use of Xopenex

WY-DUR Board 9/28/06

Trial of albuterol, bitolterol, pirbuterol or metaproterenol in the last 180 days.

Wyoming Medicaid Pharmacy Program Preferred Drug List

Effective 11/1/2006

Long Acting Opioids*

Morphine Sulfate

Calcium Channel Blockers

Verapamil

Felodipine

Diltiazem

Proton Pump Inhibitors

Prilosec OTC (omeprazole)

Protonix (pantoprazole)

ACE Inhibitors

Captopril and Captopril/HCTZ

Enalapril and Enalapril/HCTZ

Lisinopril and Lisinopril/HCTZ

Skeletal Muscle Relaxants

Cyclobenzaprine

Statins

Lescol (fluvastatin)

Pravastatin

NSAIDs

Ibuprofen

Naproxen

Overactive Bladder Agents

Oxybutynin

Detrol (tolterodine)

Ditropan XL (oxybutynin)

2nd Generation Antihistamines

Loratadine

Loratadine-D

**Additionally, Methadone does not require prior authorization.*

Drugs listed are preferred and do not require prior authorization. All other medications within the classes are nonpreferred and require prior authorization. For comparative cost information, please visit www.uwyo.edu/PDL.

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