

Eszopiclone Criteria for Use June 2016

VA Pharmacy Benefits Management Services, Medical Advisory Panel, and VISN Pharmacist Executives

*The following recommendations are based on medical evidence, clinician input, and expert opinion. The content of the document is dynamic and will be revised as new information becomes available. The purpose of this document is to assist practitioners in clinical decision-making, to standardize and improve the quality of patient care, and to promote cost-effective drug prescribing. **THE CLINICIAN SHOULD UTILIZE THIS GUIDANCE AND INTERPRET IT IN THE CLINICAL CONTEXT OF THE INDIVIDUAL PATIENT. INDIVIDUAL CASES THAT ARE EXCEPTIONS TO THE EXCLUSION AND INCLUSION CRITERIA SHOULD BE ADJUDICATED AT THE LOCAL FACILITY ACCORDING TO THE POLICY AND PROCEDURES OF ITS P&T COMMITTEE AND PHARMACY SERVICES.***

The Product Information should be consulted for detailed prescribing information.

See the VA National PBM-MAP-VPE Monograph on this drug at www.pbm.va.gov or <http://vawww.pbm.va.gov> for further information.

Transitioning Veteran (*This medication is on the DoD VHA Transitional Continuity of Care Drug List. If the criterion is met, then the remainder of the criteria for use is not applicable*)

- Veteran is transitioning care from Department of Defense to VHA. A VA prescriber, after assessing and consulting with the Veteran, has determined that continuing the medication is safe and clinically appropriate.

Exclusion Criteria: *If ANY item below is met, then the patient should NOT receive eszopiclone.*

- Active substance use disorder.
 Previous anaphylactic or anaphylactoid reaction to eszopiclone.
 Concurrent use with other scheduled sedative hypnotics used for the treatment of symptoms related to insomnia.
 Clinically significant untreated sleep-related breathing disorder, obstructive or central sleep apnea syndrome or central alveolar hypoventilation syndrome unless appropriate clinical assessment by relevant provider is completed.

Inclusion Criteria:

Either of the following must be fulfilled in order to meet criteria:

Improve Polysomnography (PSG) Yield or CPAP Titration:

- Premedication to improve the quality of polysomnography (PSG) or CPAP titration

OR

- Diagnosis of Insomnia Disorder AND documented intolerance/contraindication or an inadequate response to a trial of zolpidem immediate-release (IR). **In addition, one** of the following must be fulfilled to meet the criteria:

Episodic Insomnia:

- Adult patient with symptoms of sleep problems lasting at least 1 month but less than 3 months and causing daytime distress or dysfunction despite adequate opportunity for sleep.

OR

Chronic (persistent) Insomnia Disorder:

- Adult patient with difficulty initiating and/or maintaining sleep or non-restorative sleep, on at least three nights per week for at least 3 months, despite adequate opportunity to sleep resulting in significant negative impact on daytime functioning **AND** cognitive behavioral therapy for chronic insomnia (CBT-I) on site, via telemental health or non-VA care, if available and feasible has been tried as the initial treatment for chronic insomnia disorder.

Dosage and Administration:

- The recommended starting dose of eszopiclone is 1 mg immediately before bedtime with at least 7 to 8 hours remaining in bed prior to the planned time of awakening. Maximum dose in adults is 3 mg/day. Eszopiclone with other sedative hypnotics at bedtime or in the middle of the night is not recommended.
- The total dose should not exceed 2 mg in the elderly, in patients with severe hepatic impairment, or in patients co-administered with potent CYP3A4 inhibitors (e.g., ketoconazole, ciprofloxacin, diltiazem, erythromycin, verapamil).
- Caution is advised when prescribing eszopiclone to patients with compromised respiratory function.
- The effects of eszopiclone on sleep onset may be reduced if taken with or immediately after a high-fat/heavy meal.
- The pharmacokinetics of eszopiclone in men and women are similar.

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Please refer to Product Information for additional information

Issues for Consideration:

- CBT-I is associated with large overall improvement in global and sleep outcomes including in the Veteran population.¹ Educate patients that CBT-I involves learning new approaches to thoughts, including behavioral interventions, and education to improve sleep habits. Advise patients that symptoms may initially worsen before improving; however, the level of patient adherence to CBT-I strategies directly correlates with CBT-I outcomes. CBT-I compared with standard pharmacotherapy for insomnia is equally effective for episodic insomnia but more effective in chronic insomnia. If CBT-I alone does not improve insomnia, clinicians should use a shared-decision approach including a discussion of the benefits and harms to determine whether adding pharmacological therapy is appropriate.
- Cognitive behavioral therapy for insomnia (CBT-I) should be considered the initial treatment for chronic insomnia disorder. If it is not available on site, it can be provided by a qualified CBT-I provider from other facilities using telemental health. Effort should be made to increase access to treatment by training local providers. If CBT-I is available and feasible, prescribers should discuss treatment options with the patient. This discussion should include the pros and cons, including short and long term benefits of CBT-I relative to medications for sleep disorders as well as patient circumstances and preferences to determine the appropriate treatment modality.” Veterans should be referred out for non-VA CBT-I if VA-CBT-I is not available or feasible.
- Risk of impaired alertness and motor coordination, including impaired daytime function and driving, can occur. Caution patients against next-day driving and other activities that require complete mental alertness.
- Risk of next-day impairment, including impaired driving, is increased if eszopiclone is taken with less than a full night of sleep remaining, if a higher than recommended dose is taken, or if co-administered with other CNS depressants or other drugs that increase the blood levels of eszopiclone.
- Regular assessment of other drugs or conditions (e.g., chemical dependence, sleep apnea) that may be interfering with sleep should be conducted.
- Eszopiclone is a controlled substance. Providers should be mindful of signs and symptoms of abuse and/or dependence. Additive effects occur with concomitant use of other CNS depressants (e.g., benzodiazepines, opioids, tricyclic antidepressants, alcohol), including daytime use. Long-acting opioids concurrently with any sedative hypnotics should only be used by or in consultation with a practitioner with experience treating patients with long-acting opioids. The lowest dose effective to treat an individual’s symptoms should be used.
- Following rapid dose decrease or abrupt discontinuation of the use of any sedative hypnotics, signs and symptoms similar to those associated with withdrawal from other CNS-depressant drugs, have been reported.
- Eszopiclone is Pregnancy Category C. Eszopiclone in women of childbearing potential, or those breastfeeding, or planning to breastfeed should only be considered if the potential benefit justifies the potential risk to the fetus.
- Dysgeusia upon awakening may occur with eszopiclone. Counsel patients experiencing unpleasant taste (metallic) to brush teeth, drink juice, and eat breakfast. Also, confirm with patient that eszopiclone tablet is being taken intact.

Initial Prescription/Monitoring Criteria

- Episodic Insomnia: (symptoms lasting at least 1 month but less than 3 months)
 - Initial prescription should be limited to a 30 day supply with a maximum of 2 refills. It is strongly recommended that patients be evaluated via telephone/telehealth within 3-5 weeks of the dispense date of prescription by the provider or a registered/licensed healthcare professional (e.g., pharmacy/nursing personnel, health technicians, social worker, or psychologist/psychiatrists) to document any improvement in the symptoms related to insomnia.
- Chronic (symptoms lasting 3 months or longer)
 - Initial prescription should be limited to a 30 day supply with maximum of 5 refills. It is strongly recommended that patients be evaluated via telephone/telehealth within 3-5 weeks of the dispense date of prescription by the provider or a registered/licensed healthcare professional (e.g., pharmacy/nursing personnel, social worker, health technicians or psychologist/psychiatrists) to document any improvement in the symptoms related to insomnia.
 - For chronic treatment, a medical record documentation that patient experienced a clinically important benefit in total sleep time, sleep onset, sleep quality or satisfaction (e.g., and/or daytime function) is required to be eligible for prescription renewal beyond 6 months. (See Renewal Criteria and/or Discontinuation Criteria)
- Treatment Monitoring for Episodic and Chronic Insomnia: For appointments/follow-up calls from provider/service responsible for monitoring therapy, it is recommended insomnia quality measures (see Under Renewal Criteria), possible CNS depressant effects, next-day impairment of driving and other activities, and any abnormal thinking and behavioral changes be documented in the medical record. Documentation that patient/caregiver/family were reminded that somnolence,

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CNS depressant effects, and next-day impairment (including driving) can occur in the absence of symptoms and that instructions were provided and documented to patient/caregiver/family to immediately report any changes in behavior to the provider/medical team is also recommended.

Renewal Criteria and Refill for Chronic Insomnia (All items must be fulfilled)

- A medical record documentation of improvement **POST** treatment in total sleep time, sleep onset, or quality of sleep compared to **PRE** treatment.
Areas of improvement related to quality of sleep could include: affect (mood, anxiety); cognitive function (attention, memory, concentration); educational/academic or vocational/occupational functioning; social, familial, or interpersonal functioning; fatigue; daytime sleepiness; energy/motivation; somatic complaints (tension, headache, stomach upset); or general distress about ongoing sleep difficulties.²
- Ongoing assessment of treatment adherence, including follow-up appointments.
- Patient tolerates treatment and an assessment of treatment-related side effects is documented.
- Maximum duration of treatment is 5 months after initial Rx (e.g. 6 months total) for chronic insomnia, unless there is continuation of documentation of patient benefits and acceptable risks beyond 6 months. If no documented improvement, consider referral to a sleep specialist, psychiatrist, or locally designated VA Sleep Expert provider for evaluation.

Discontinuation Criteria for Chronic Insomnia (if any of the following is checked, eszopiclone should be discontinued)

- No improvement in sleep duration, sleep initiation, or quality of sleep² (e.g., affect (mood, anxiety); cognition (attention, memory, concentration); educational/academic or vocational/occupational functioning; social, familial, or interpersonal functioning; fatigue; daytime sleepiness; motivation and energy; and somatic complaints (tension, headache, stomach upset) and general distress about ongoing sleep difficulties.
- Any abnormal thinking and behavioral changes (e.g., complex sleep behavior such as sleep-walking, sleep eating, sexual activity during sleep, making phone calls) and/or any intolerable treatment-related side effects (e.g., sedation during waking hours, particularly upon awakening; headache, nausea and other GI disturbances; nightmares; cognitive effects (e.g., memory loss, confusion, disorientation); psychomotor effects (e.g., dizziness, balance impairment, falls); motor vehicle and other accidents; depression).
- Mutual agreement between patient and/or caregiver that agent is not providing any benefit in sleep quality or satisfaction and/or daytime function.

Prepared: July 2016. Contact: Janet H. Dailey, VA Pharmacy Benefits Management Services

1. Trockel M, Karlin BE, Taylor CB, Manber R. Cognitive behavioral therapy for insomnia with veterans: evaluation of effectiveness and correlates of treatment outcomes. *Behav Res Ther.* 2014; 53:41-6.
2. Edinger JD, Buysse DJ, Deriy L et al. Quality measures for the care of patients with insomnia. <http://dx.doi.org/10.5664/jcsm.4552>

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