Effective Date: 12/01/2020
Revised: 9/2020 Reviewed: 9/2020 Scope: Medicaid

Dayvigo (lemborexant)

POLICY

I. CRITERIA FOR APPROVAL

An authorization may be granted when all the following criteria are met:

A. The member has a documented diagnosis of insomnia disorder, **AND**
B. Member is at least 18 years of age, **AND**
C. Member has tried and failed OR had an intolerance or contraindication to at least three formulary alternatives (i.e., zolpidem, trazodone, temazepam etc.), **OR**
D. Member has a documented history of known substance use disorder and/or is receiving current treatment for addiction, in which case most formulary alternatives may be deemed inappropriate, **AND**
E. Dose does not exceed one tablet (10mg) a day

II. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for all members who meet all initial criteria and who have documentation of a positive clinical response after at least 6 months of therapy with Dayvigo.

III. QUANTITY LIMIT

- 30 tablets per 30 days

IV. COVERAGE DURATION

- 12 months

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