Clinical Policy: Armodafinil (Nuvigil)

Reference Number: IL.PMN.35
Effective Date: 6.1.23
Last Review Date: 4.18.23
Line of Business: Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Armodafinil (Nuvigil®) is a wakefulness-promoting agent.

FDA Approved Indication(s)
Nuvigil is indicated to improve wakefulness in adult patients with excessive sleepiness associated with obstructive sleep apnea (OSA), narcolepsy, or shift work disorder (SWD).

Limitation(s) of use: In OSA, Nuvigil is indicated to treat excessive sleepiness and not as treatment for the underlying obstruction. If continuous positive airway pressure (CPAP) is the treatment of choice for a patient, a maximal effort to treat with CPAP for an adequate period of time should be made prior to initiating Nuvigil for excessive sleepiness.

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

It is the policy of health plans affiliated with Centene Corporation® that armodafinil is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Narcolepsy (must meet all)**:**

1. Diagnosis of narcolepsy;
2. Prescribed by or in consultation with a neurologist or sleep medicine specialist;
3. Age ≥ 17 years;
4. Member must use generic modafinil, unless contraindicated or clinically significant adverse effects are experienced;
5. Failure of a 1-month trial of one of the following generic central nervous system stimulant-containing agent at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated: amphetamine, dextroamphetamine, or methylphenidate;
   **Prior authorization may be required for CNS stimulants*
6. Dose does not exceed both of the following (a and b):
   a. 250 mg per day;
   b. 1 tablet per day.

Approval duration:
Medicaid– 12 months

B. Obstructive Sleep Apnea/Hypopnea Syndrome (must meet all)**:**
1. Diagnosis of OSA;
2. Age ≥ 17 years;
3. Member must use generic modafinil, unless contraindicated or clinically significant adverse effects are experienced;
4. Documented evidence of residual sleepiness despite compliant CPAP use as monotherapy;
5. Dose does not exceed both of the following (a and b):
   a. 250 mg per day;
   b. 1 tablet per day.

Approval duration:
Medicaid

C. Shift Work Disorder (SWD) (must meet all)**:**
1. Diagnosis of SWD;
2. Age ≥ 17 years;
3. Member must use generic modafinil, unless contraindicated or clinically significant adverse effects are experienced;
4. Dose does not exceed both of the following (a and b):
   a. 150 mg per day;
   b. 1 tablet per day.

Approval duration: 12 months

D. Fatigue Associated with Multiple Sclerosis (MS) (off-label) (must meet all)**:**
1. Diagnosis of MS-associated fatigue;
2. Age ≥ 17 years;
3. Failure of 200 mg/day of amantadine and ≥ 10 mg/day of methylphenidate, unless contraindicated or clinically significant adverse effects are experienced;
4. Member must use generic modafinil, unless contraindicated or clinically significant adverse effects are experienced;
5. Dose does not exceed both of the following (a and b):
   a. 250 mg per day;
   b. 1 tablet per day.

Approval duration:
Medicaid – 12 months

E. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. Member must use generic armodafinil, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, new dose does not exceed:
   a. Narcolepsy, OSA, and MS-associated fatigue (both i and ii):
      i. 250 mg per day;
      ii. 1 tablet per day;
   b. SWD (both i and ii):
      i. 150 mg per day;
      ii. 1 tablet per day.

Approval duration:
Medicaid – 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CPAP: continuous positive airway pressure
FDA: Food and Drug Administration
IR: immediate-release
MS: multiple sclerosis
OSA: obstructive sleep apnea
SWD: shift work disorder

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
amphetamine (Evekeo®)	**Narcolepsy** 5 to 60 mg/day PO in divided doses	60 mg/day
amphetamine/ dextroamphetamine (Adderall®)		
dextroamphetamine ER (Dexedrine® Spansule®)		
dextroamphetamine IR (Zenzedi®, Procentra®)		
methylphenidate (Ritalin® LA or SR, Concerta®, Metadate® CD or ER, Methylin® ER, Daytrana®)	**Narcolepsy** Dosing varies; 10-60 mg PO divided 2 to 3 times daily 30-45 min before meals **MS-related fatigue**† Usual effective dose: 10-20 mg PO QAM and noon	60 mg/day
amantadine (Symmetrel®)	**MS-associated fatigue**† 200 mg PO once daily or 100 mg PO twice daily	200 mg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
†*Off-label indication*

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Narcolepsy	150 mg to 250 mg PO once a day	250 mg/day
OSA		
SWD	150 mg PO once a day as a single dose approximately 1 hour prior to the start of work shift	150 mg/day
MS-associated fatigue (off-label)	150 mg PO every morning	250 mg/day

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): known hypersensitivity to modafinil or armodafinil
- Boxed warning(s): none reported

VI. Product Availability

Tablets: 50 mg, 150 mg, 200 mg, and 250 mg

VII. References

1. Nuvigil Prescribing Information. North Wales, PA: Teva Pharmaceuticals USA, Inc.; February 2017. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/021875s023lbl.pdf. Accessed February 7, 2023.
2. Morgenthaler TI, Kapur VK, Brown T, et al. Practice Parameters for the Treatment of Narcolepsy and other Hypersomnias of Central Origin An American Academy of Sleep Medicine Report: An American Academy of Sleep Medicine Report. *Sleep*. 2007;30(12):1705-1711.
3. Epstein LJ, Kristo D, Strollo PJ Jr, et al. Clinical guideline for the evaluation, management and long-term care of obstructive sleep apnea in adults. *J Clin Sleep Med*. 2009;5(3):263-76.
4. Morgenthaler TI, Lee-Chiong T, Alessi C, et al. Practice Parameters for the Clinical Evaluation and Treatment of Circadian Rhythm Sleep Disorders: An American Academy of Sleep Medicine Report. *Sleep*. 2007;30(11):1445-1459.
5. Bassetti CL, Kallweit U, Vignatelli, et al. European guideline and expert statements on the management of narcolepsy in adults and children. J Sleep Res. 2021;00:e13387. DOI: 10.1111/jsr.13387.
6. Management of MS-Related Fatigue. Expert Opinion Paper. National Multiple Sclerosis Society; 2006. Available at: http://www.nationalmssociety.org/NationalMSSociety/media/MSNationalFiles/Brochures/Opinion-Paper-Management-of-MS-Related-Fatigue.pdf.
7. Braley TJ; Chervin RD. Fatigue in multiple sclerosis: mechanisms, evaluation, and treatment. *Sleep.* 2010;33(8):1061-1067.
8. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2023. Available at: https://www.clinicalkey.com/pharmacology/. Accessed February 7, 2023.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Adapted from CP.PMN.35 per HFS regulation	4.18.23	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical

practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.