

QUICK GUIDE

Treatment of chronic insomnia with QUVIVIQ™ ▼ (daridorexant) - a quick guide

Disclaimer: The views expressed in this guide reflect the individual clinical practice of the author; the effect of daridorexant can vary from patient to patient. QUVIVIQ™ is indicated for the treatment of adult patients with insomnia characterised by symptoms present for at least 3 months and considerable impact on daytime functioning. ©Cogora 2025. The contents of this publication are protected by copyright. All rights reserved. The contents of this publication, either in whole or in part, may not be reproduced, stored in a data retrieval system or transmitted in any forms or by any means, electronic, mechanical, photocopying, recording or otherwise, without written permission of the publisher. First published 2025 by Cogora, 1 Giltspur Street, London EC1A 9DD.



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Awareness of predisposing, precipitating and perpetuating factors can help us to **understand a patient’s insomnia and to select optimal treatments**¹. Acute insomnia often resolves when the precipitant is addressed or the patient has adjusted to the event². Chronic insomnia is driven, instead, by predisposing factors (e.g., overactive wake signalling)³ and perpetuating factors (e.g., maladaptive sleep habits⁴).

There is **no evidence that sleep hygiene works for chronic insomnia in isolation**, being more effective with cognitive behavioural therapy for insomnia (CBTi)⁵. Some healthcare professionals consider sleep hygiene to simply delay the introduction of more effective insomnia treatments⁶. In my practice, many patients presenting with insomnia have already tried it.

Cognitive behavioural therapy for insomnia, which is distinct from other forms of CBT, can address maladaptive sleep habits^{7,8}. However, specialist CBTi access is limited. Some digital CBTi solutions are available on the NHS⁹, and self-help manuals may support motivated patients. In primary care, behavioural interventions – such as stimulus control and sleep restriction – can be effective¹⁰.

If CBTi is unavailable, unsuitable, or ineffective, NICE recommend daridorexant for chronic insomnia¹¹. For people over 55 years of age, prolonged-release melatonin may be considered up to a maximum of 13 weeks.⁵

Daridorexant is a dual orexin receptor antagonist. It works by dampening wakefulness signals, allowing sleep to occur naturally and preserving normal sleep architecture¹². Many of my patients value this difference – particularly those who describe feeling “tired but wired” at night or who have not had success with traditional sedatives.

Patient statements that may indicate daridorexant as an option to consider:

- “I’m wide awake the minute my head hits the pillow”
- “I don’t feel like my brain ever switches off at night”
- “I keep waking at 4am and can’t stop thinking”

Clinical data shows that daridorexant 50 mg reduces sleep onset time by around 30 minutes from baseline and decreases wake time after sleep onset by a similar amount¹². As a result, a person with chronic insomnia might expect about an extra hour of sleep per night* – a meaningful improvement for many patients¹³.

*Effects of daridorexant can vary from patient to patient.

Continued overleaf →

Unlike other sleeping tablets, daridorexant can take a few weeks to have its full impact, although each patient is different and some may notice effects within a day or two with others requiring up to a month for its effects to be felt¹⁴. It's crucial to counsel patients that, unlike the immediate "knock-out" sensation of some sleep medications, daridorexant works gradually. Aligning patient expectations improves adherence, and ultimately, the outcome. It should be taken at the **same time every night**, 30 minutes before going to bed. *Pro re nata* (PRN) dosing is not indicated – daridorexant is a long-term treatment taken regularly. If a patient wishes to stop using an existing sleep medication (e.g. a central nervous system (CNS) depressant), they should be weaned off gradually¹⁵. Consider a short "wash-out" period (ideally whilst completing a sleep diary) before initiating daridorexant¹⁵. In contrast, modified-release melatonin may be discontinued abruptly before starting daridorexant¹⁵.

Most patients can be started on the recommended 50 mg dose, without the need for up-titration. Patients with moderate hepatic impairment (Child–Pugh Score 7–9), taking moderate CYP3A4 inhibitors (e.g., verapamil, fluconazole, diltiazem) or those with dose-related side effects may use a 25 mg dose. For patients on warfarin, citalopram or contraceptives, no dose adjustments are required.

● **Contraindications**¹²: narcolepsy, hypersensitivity (to the active substance or excipients), concomitant use with strong CYP3A4 inhibitors

● **Cautions**¹²: Severe chronic obstructive pulmonary disease, psychiatric illness, concomitant administration with CNS-depressant medications – please refer to daridorexant SmPC for full list of cautions¹²

– High-dose simvastatin, tacrolimus (sensitive CYP3A4 substrates with a narrow therapeutic index), digoxin (P-gp substrates with a narrow therapeutic index)

● **Interactions**^{12,16}:

– Contraindicated: Clarithromycin, itraconazole, ritonavir (strong CYP3A4 inhibitors)

– Avoid: Grapefruit and grapefruit juice in the evening

– Dose adjustment to 25 mg: erythromycin, ciprofloxacin, verapamil, fluconazole, diltiazem (moderate CYP3A4 inhibitors)

– No interaction: warfarin, citalopram, rosuvastatin, contraceptives

Potential side effects include headache and somnolence, and uncommonly, sleep paralysis (in the first few weeks of treatment²³). Driving studies show that daridorexant impairs performance after the first night, but this resolves after 4 consecutive nights¹². In comparison, zopiclone significantly impaired driving performance at both time points¹². While no sleep medication is perfect for those seeking to feel alert in the morning, daridorexant may be a suitable option. For caregivers who need to wake quickly, data have shown that patients treated with daridorexant maintained their ability to awaken to external noise stimulus, on par with placebo¹⁷.

After initiation, patients should be **reviewed within 3 months** (and periodically thereafter¹⁸). Treatment duration should be as

short as possible¹¹. **No evidence of withdrawal, dependence or rebound insomnia** with daridorexant was found in large phase 3 clinical trials¹², which is an important consideration given an increasing focus on reducing prescriptions for potentially addictive medications.

Top tips for starting your patients on daridorexant:

- 1 Explain** that daridorexant works by reducing wakefulness rather than inducing sedation, and tailor the explanation to the patient's experience ("tired but wired", "brain doesn't switch off")
- 2 Set realistic expectations:** There's no immediate "knock-out" sensation, and depending on each individual case, it can take from a day or two up to a month for its effects to be felt/experienced¹⁴
- 3 Advise the patient to take it every night**, not PRN, and caution about the use of additional CNS depressants (avoiding alcohol and co-administration of other "sleep" medications)
- 4 Incorporate CBTi where you can** to maximise the improvements and reduce the risk of relapse when treatment ends

References

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Adverse events must be reported. Healthcare professionals are asked to report any suspected adverse reactions via www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in Google play or Apple App store. Adverse events should also be reported to ds.safety.uk@idorsia.com

Prescribing information for QUVIVIQ™ (daridorexant) can be found at: <https://prescribing-information-quviviq.idorsia.uk/>

