SPECIALTY GUIDELINE MANAGEMENT

ZOLINZA (vorinostat)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indication
Treatment of cutaneous manifestations in patients with cutaneous T-cell lymphoma who have progressive, persistent, or recurrent disease on or following two systemic therapies

B. Compendial Uses
1. Mycosis fungoides (MF)
2. Sézary syndrome (SS)

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

Cutaneous T-cell Lymphoma (CTCL)
Authorization of 12 months may be granted for the treatment of CTCL (e.g., MF, SS, etc.).

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

1. Zolinza [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; December 2015.
2. The NCCN Drugs & Biologics Compendium™ © 2016 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed December 5, 2016.
3. National Comprehensive Cancer Network. NCCN clinical practice guidelines in oncology: Non-Hodgkin's Lymphomas. Version 3.2016. http://www.nccn.org/professionals/physician_gls/pdf/nhl.pdf. Accessed December 5, 2016.