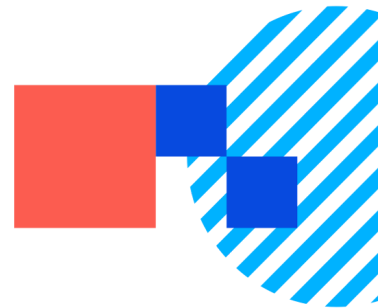




## Voxzogo Prior Authorization Drug List A

|                  |                      |
|------------------|----------------------|
| Drug(s) Applied: | Voxzogo (vosoritide) |
|------------------|----------------------|

### Criteria:

Drug(s) Applied will be approved when the requested medication is being used for an FDA approved indication and all of the following criteria are met:

#### I. Initial Therapy Criteria

##### A. **Achondroplasia** as indicated by chart notes within past 120 days

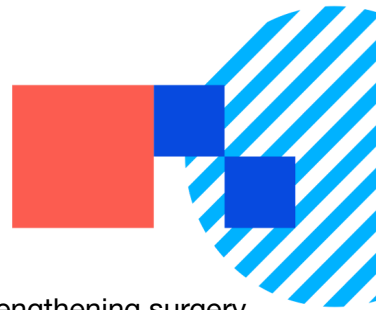
1. Diagnosis confirmed by positive genetic test for FGFR3 variant **and**
2. If 13 years of age or older, OR if growth velocity  $< 1.5$  cm/year, confirmation of open epiphyses as determined by imaging (e.g., MRI, x-ray) within the past year **and**
3. Patient is under 15 years old **and**
4. Baseline growth has been established with measurements spanning at least 6 months **and**
5. Chart notes do not indicate the member will undergo limb-lengthening surgery while taking the requested agent and has not undergone this surgery in the past 18 months **and**
6. Patient has not received treatment within the past 6 months with another growth stimulating agent such as growth hormone, and will not be using Voxzogo in combination with such agents **and**
7. Prescriber is a specialist in the area of the patient's diagnosis (e.g., pediatric endocrinology)

**Approval Duration:** 2 months

#### II. Continued Therapy Criteria

##### A. **Achondroplasia** as indicated by chart notes within past 6 months

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization process or meets the initial therapy criteria above **and**
2. ONE of the following:
  - a) Annual height velocity  $\geq 1.5$  cm per year in the past year **or**
  - b) Annual height velocity  $< 1.5$  cm per year in the past year, and patient has open epiphyses as validated by recent imaging in the past year (e.g., MRI, x-ray) **and**



3. Chart notes do not indicate the member will undergo limb-lengthening surgery while taking the requested agent and has not undergone this surgery in the past 18 months **and**
4. Patient has not received treatment within the past 6 months with another growth stimulating agent such as growth hormone, and will not be using Voxzogo in combination with such agents **and**
5. Prescriber is a specialist in the area of the patient's diagnosis (e.g., pediatric endocrinology)

**Approval Duration:** 2 months

**References:**

1. Voxzogo prescribing information. BioMarin Pharmaceutical Inc. November 2024.
2. Savarirayan R, Tofts L, Irving M, et al. Once-daily, subcutaneous vosoritide therapy in children with achondroplasia: a randomised, double-blind, phase 3, placebo-controlled, multicentre trial. *Lancet*. 2020 Sep 5;396(10252):684-692.
3. Savarirayan R, Irving M, Wilcox WR, et al. Sustained growth-promoting effects of vosoritide in children with achondroplasia from an ongoing phase 3 extension study. *Med*. 2025;6(5):100566.
4. Savarirayan, R., Hoover-Fong, J., Ozono, K. et al. International consensus guidelines on the implementation and monitoring of vosoritide therapy in individuals with achondroplasia. *Nat Rev Endocrinol* 21, 314–324 (2025).

**Policy Owned by:** Curative PBM team