curative

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 >= 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