

## Voxzogo Prior Authorization Drug List A

Drug(s) Applied:	Voxzogo (vosoritide)
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### 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. Requested agent will be used to increase linear growth **and**
3. Patient has either:
  - a) Open epiphyses as validated by recent imaging (e.g., MRI, x-ray) within the past year **or**
  - b) Tanner Stage <4 **and**
4. Patient is age 5 to 15 years old **and**
5. Baseline growth has been established with measurements spanning at least 6 months **and**
6. 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**
7. 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**
8. Prescriber is a specialist in the area of the patient's diagnosis (e.g., pediatric endocrinology)

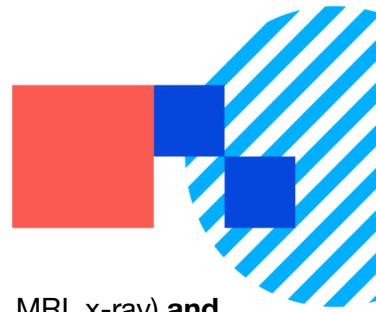
**Approval Duration:** 2 months

#### 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 (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 Voxelzogen 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

**Policy Owned by:** Curative PBM team

