Clinical Policy: Vorinostat (Zolinza)

Reference Number: ERX.SPA.83
Effective Date: 03.01.14
Last Review Date: 08.21
Line of Business: Commercial, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Vorinostat (Zolinza®) is histone deacetylase (HDAC) inhibitor.

FDA Approved Indication(s)
Zolinza is indicated for the treatment of cutaneous manifestations in patients with cutaneous T-cell lymphoma (CTCL) who have progressive, persistent or recurrent disease on or following two systemic therapies.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

Health plan approved formularies should be reviewed for all coverage determinations. Requirements to use preferred alternative agents apply only when such requirements align with the health plan approved formulary.

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ that Zolinza is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Cutaneous T-Cell Lymphoma (must meet all)**:**

1. Diagnosis of CTCL;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Request meets one of the following (a or b):*
   a. Dose does not exceed 400 mg (4 capsules) per day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Commercial – Length of Benefit
Medicaid – 6 months

B. Other diagnoses/indications

1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Cutaneous T-Cell Lymphoma (must meet all)**:**

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions or documentation supports that member is currently receiving Zolinza for CTCL and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 400 mg (4 capsules) per day;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Commercial – Length of Benefit
Medicaid – 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off-label use policy – ERX.PA.01 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CTCL: cutaneous T-cell lymphoma
FDA: Food and Drug Administration
HDAC: histone deacetylase
NCCN: National Comprehensive Cancer Network

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
None reported

*Appendix D: World Health Organization-European Organization for Research and Treatment of Cancer, 2018 - Classification of CTCL**

- Mycosis fungoides (MF)
  - MF variants and subtypes
    - Folliculotropic MF
    - Pagetoid reticulosis
    - Granulomatous slack skin
- Sezary syndrome (SS)
- Adult T-cell leukemia/lymphoma (ATLL)
- Primary cutaneous CD30+ lymphoproliferative disorders
  - Cutaneous anaplastic large cell lymphoma (ALCL)
  - Lymphomatoid papulosis
- Subcutaneous panniculitis-like T-cell lymphoma
- Extranodal NK**/T-cell lymphoma, nasal type
- Chronic active EBV infection
- Primary cutaneous peripheral T-cell lymphoma, rare subtypes
  - Primary cutaneous gamma-delta T-cell lymphoma
  - Primary cutaneous aggressive epidermotropic CD8+ cytotoxic T-cell lymphoma (CD8+ AECTCL)
  - Primary cutaneous CD4+ small/medium-sized T-cell lymphoproliferative disorder
  - Primary cutaneous acral CD8+ T-cell lymphoma
- Primary cutaneous peripheral T-cell lymphoma, NOS

**Non-Hodgkin's lymphomas (NHLs) include lymphoproliferative disorders originating in B-lymphocytes, T-lymphocytes, and natural killer cells. Cutaneous T-cell lymphomas (CTCLs) are a subset of NHLs characterized by skin involvement and the potential to progress to lymph nodes, blood, and visceral organs. Mycosis fungoides, the most common CTCL, is an extranodal NHL of mature T-cells with primary skin involvement. Sezary syndrome, a less common CTCL, is characterized by significant blood involvement and lymphadenopathy.*
***Extranodal NK-cell lymphoma is considered a CTCL subtype under the policy criteria.*

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CTCL	400 mg PO QD	400 mg/day

VI. Product Availability

Capsule: 100 mg

VII. References

1. Zolinza Prescribing Information. Whitehouse Station, NJ: Merck and Company, Inc.; January 2020. Available from http://www.merck.com/product/usa/pi_circulars/z/zolinza/zolinza_pi.pdf. Accessed March 18, 2021.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed March 18, 2021.
3. National Comprehensive Cancer Network. Primary Cutaneous Lymphomas Version 2.2021. Available at: http://www.nccn.org. Accessed March 18, 2021.
4. Willemze R, Cerroni L, Kempf W, et al. WHO-EORTC classification for primary cutaneous lymphomas. Blood 2019;133:1703-1714.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Converted to new template. Added NCCN recommended uses and appendix for CTCL classification. Changed approved durations from 3 and 6 to 6 and 12 months.	07.01.17	08.17
3Q 2018 annual review: no significant changes; age and specialist requirements added; continuation of care statement added; NCCN and FDA-approved uses summarized for improved clarity (criteria limited to CTLC diagnosis); references reviewed and updated.	05.08.18	08.18
3Q 2019 annual review: no significant changes; added Medicaid line of business with 6/12 month approval durations; references reviewed and updated.	05.14.19	08.19
3Q 2020 annual review: no significant changes; Appendix D subtype classification updated per NCCN/WHO-EORTC 2018; references reviewed and updated.	05.12.20	08.20
3Q 2021 annual review: no significant changes; references reviewed and updated.	03.18.21	08.21

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information.

This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members.