

PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Zolinza Prior Authorization Policy

- Zolinza® (vorinostat capsules – Merck)

REVIEW DATE: 07/22/2020

OVERVIEW

Zolinza, a histone deacetylase inhibitor, is indicated for the treatment of cutaneous manifestations in patients with cutaneous T-cell lymphoma who have progressive, persistent or recurrent disease on or following two systemic therapies.¹

Guidelines

The National Comprehensive Cancer Network (NCCN) clinical practice guidelines for primary cutaneous lymphomas (Version 2.2020 – April 10, 2020) list Zolinza as a preferred systemic therapy for mycosis fungoides/Sezary syndrome.^{2,3} Zolinza can be used for primary treatment or for relapsed, persistent, or refractory disease.

POLICY STATEMENT

Prior authorization is recommended for prescription benefit coverage of Zolinza. All approvals are provided for the duration noted below.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Zolinza is recommended in those who meet the following criteria:

FDA-Approved Indications

1. **Cutaneous T-Cell Lymphoma including Mycosis Fungoides/Sezary Syndrome.** Approve for 3 years.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Zolinza is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Zolinza® capsules [prescribing information]. Whitehouse Station, NJ: Merck & Co.; December 2018.
2. The NCCN Primary Cutaneous Lymphomas Clinical Practice Guidelines in Oncology (Version 2.2020 – April 10, 2020). © 2020 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed July 15, 2020.
3. The NCCN Drugs and Biologics Compendium. © 2020 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed on Jul 15, 2020. Search term: vorinostat.