PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Zolinza Prior Authorization Policy
- Zolinza® (vorinostat capsules – Merck)

REVIEW DATE: 07/31/2024

OVERVIEW
Zolinza, a histone deacetylase inhibitor, is indicated for the treatment of cutaneous manifestations of **cutaneous T-cell lymphoma** in patients 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 2.2024 – May 6, 2024) recommend Zolinza as a 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 Indication

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

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.; July 2022.
2. The NCCN Primary Cutaneous Lymphomas Clinical Practice Guidelines in Oncology (version 2.2024 – May 6, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed July 25, 2024.
3. The NCCN Drugs and Biologics Compendium. © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on July 25, 2024. Search term: vorinostat.