Vosoritide (Voxzogo™)	**Place of Service** **Self Administration** *May be covered under the pharmacy benefit* **HCPCS: J3490** **NDCs:** 68135-082-36: 0.4 mg 68135-119-66: 0.56 mg 68135-181-93: 1.2 mg

Condition(s) listed in policy (*see criteria for details*)

- Achondroplasia

AHFS therapeutic class: Miscellaneous agents

Mechanism of action: C type natriuretic peptide analog

(1) Special Instructions and pertinent Information

This drug is managed under the outpatient Pharmacy Benefit for self-administration. Please contact the member's Pharmacy Benefit for information on how to obtain this drug.

To submit a request to the Medical Benefit, please submit clinical information for prior authorization review and include medical rationale why the patient cannot self-administer this drug in the home.

For plans with self-injectables only covered under the Medical Benefit, please submit clinical information for prior authorization review.

(2) Prior Authorization/Medical Review is required for the following condition(s)

All requests for Voxzogo® (vosoritide) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

Achondroplasia

1. Prescribed by or in consultation with a skeletal dysplasia specialist (i.e., experts in orthopedics, neurosurgery, genetics, pediatric endocrinologists), **AND**
2. Patient is at least 5 years old, **AND**
3. Patient has a growth rate over one year (annualized growth velocity, AGV) of 1.5 centimeters/year or greater, **AND**
4. Provider attestation that patient has open epiphyses

Covered Doses

Dose based on body weight and given SC once daily

Actual body weight (kg)	Vial Strength for reconstitution	Dose (mg)

10-11	0.4 mg	0.24
12-16	0.56 mg	0.28
17-21	0.56 mg	0.32
22-32	0.56 mg	0.4
33-43	1.2 mg	0.5
44-59	1.2 mg	0.6
60-89	1.2 mg	0.7
≥ 90	1.2 mg	0.8

Coverage Period
Initial authorization: 1 year

Reauthorizations: 1 year if meets all the below
1. Patient has an increase in growth rate from baseline, and
2. Provider attestation that patient has open epiphyses, and
3. Dose does not exceed FDA label maximum

ICD-10:
Q77.4

(3) The following condition(s) DO NOT require Prior Authorization/Preservice
All requests for Voxzogo® (vosoritide) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

(4) This Medication is NOT COVERED for the following condition(s)
Coverage for a Non-FDA approved indication, requires that criteria outlined in Health and Safety Code § 1367.21, including objective evidence of efficacy and safety are met for the proposed indication.

Please refer to the Provider Manual and User Guide for more information.

(5) Additional Information
How supplied:
0.4 mg, 0.56 mg, or 1.2 mg lyophilized powder in a single-dose vial for reconstitution.

(6) References

- AHFS®. Available by subscription at http://www.lexi.com
- DrugDex®. Available by subscription at http://www.micromedexsolutions.com/home/dispatch
- Voxzogo (vosoritide) [Prescribing information]. Novato, CA: BioMarin Pharmaceutical Inc; 11/2021.

(7) Policy Update
Date of last review: 1Q2023
Date of next review: 1Q2024
Changes from previous policy version:
- No clinical change to policy following routine annual review.