

## vosoritide (Voxzogo)

### Commercial Pharmacy Benefit Drug Policy

[Specialty Pharmacy Drug List](#)

#### Drug Details

**USP Category:** GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT

**Mechanism of Action:** acts as a positive regulator of endochondral bone growth as it promotes chondrocyte proliferation and differentiation

Label Name	Quantity Limit
Voxzogo 0.4 MG RECON SOLN	1 vial/day
Voxzogo 0.56 MG RECON SOLN	1 vial/day
Voxzogo 1.2 MG RECON SOLN	1 vial/day

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

- Achondroplasia

Any condition not listed in this policy requires a review to confirm it is medically necessary. For conditions that have not been approved for intended use by the Food and Drug Administration (i.e., off-label use), the criteria outlined in the Health and Safety Code section 1367.21 must be met.

#### Special Instructions and pertinent Information

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

Members with Specialty Tier benefit MUST obtain specialty drugs through our contracted specialty pharmacies for medication to be covered.

#### The following condition(s) require Prior Authorization/Preservice:

##### Achondroplasia

##### Initial authorization:

1. Patient has a growth rate over one year (annualized growth velocity, AGV) of 1.5 centimeters/year or greater, **and**
2. Patient has open epiphyses, **and**
3. Prescribed by or in consultation with a skeletal dysplasia specialist (i.e., experts in orthopedics, neurosurgery, genetics, pediatric endocrinologists), **and**
4. Dose does not exceed FDA label maximum .

##### Reauthorization:

1. Patient has an increase in growth rate (annualized growth velocity, AGV) from baseline, **and**
2. Patient has open epiphyses, **and**
3. Dose does not exceed FDA label maximum .

**Coverage Period:**

12 months

**Additional Information**

- VOXZOGO is a C type natriuretic peptide (CNP) analog indicated to increase linear growth in pediatric patients with achondroplasia who are 5 years of age and older with open epiphyses. This indication is approved under accelerated approval based on an improvement in annualized growth velocity. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s).
- **Recommended VOXZOGO Daily Dosage**

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

**References**

1. Product Information: VOXZOGO (TM) vosoritide subcutaneous injection. BioMarin Pharmaceutical Inc. (per FDA), Novato, CA, 2023.

**Review History**

Date of Last Annual Review: 1Q2024

Date of last revision: 04/03/2024

Changes from previous policy version:

- No clinical change following annual review.

*Blue Shield of California Medication Policy to Determine Medical Necessity  
Reviewed by P&T Committee*