

Clinical Pharmacy Program Guidelines for Zolinza

Program	Prior Authorization
Medication	Zolinza (vorinostat)
Issue Date	12/2014
Pharmacy and Therapeutics Approval Date	11/2017
Effective Date	1/2018

1. Background:

Zolinza is indicated 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.

2. Coverage Criteria:

<p>A. <u>Initial Authorization</u></p> <p>1. Diagnosis of cutaneous T-cell lymphoma</p> <p style="text-align: center;">-AND-</p> <p>2. History of failure, contraindication, or intolerance to at least two systemic therapies</p> <p style="text-align: center;">Authorization will be issued for 12 months.</p> <p>B. <u>Reauthorization</u></p> <p>1. Patient does not show evidence of progressive disease while on Zolinza therapy</p> <p style="text-align: center;">Authorization will be issued for 12 months.</p>
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Examples of systemic therapies include (but are not limited to): • Campath (alemtuzumab) • Cytosan (cyclophosphamide) • Doxil (pegylated doxorubicin) • Extracorporeal photochemotherapy • Folutyn (pralatrexate) • Gemzar (gemcitabine) • Interferon-alpha •

Leukeran (chlorambucil) • Nipent (pentostatin) • Ontak (denileukin diftitox) • Targretin (bexarotene) • Temodar (temozolamide) • Toposar (etoposide) • Trexall (methotrexate) • Velcade (bortezomib)

3. References:

1. Zolinza Prescribing Information. Merck & Co, Inc., December 2015.
2. National Cancer Institute. Mycosis fungoides and the Sezary Syndrome (PDQ®) Treatment. Available at: <http://www.nci.nih.gov/cancertopics/pdq/treatment/mycosisfungoides/HealthProfessional> . Accessed January 2, 2007.
3. Whittaker SJ, Marsden JR, Spittle M, Jones RR. Joint British Association of Dermatologists and U.K. Cutaneous Lymphoma Group guidelines for the management of primary cutaneous T-cell lymphomas. Br J Dermatol. 2003;149:1095-1107.
4. National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology™ Non-Hodgkin's Lymphomas (Version 4.2011). Available at: http://www.nccn.org/professionals/physician_gls/PDF/nhl.pdf. Accessed September 16, 2011.

Program	Prior Authorization - Zolinza (vorinostat)
Change Control	
Date	Change
12/2014	New policy
11/2016	Annual review; updated policy template and added reauthorization criteria
11/2017	Annual review. Updated references.