UnitedHealthcare Community Plan

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:

A. Initial Authorization

1. Diagnosis of cutaneous T-cell lymphoma

-AND-

2. History of failure, contraindication, or intolerance to at least two systemic therapies

Authorization will be issued for 12 months.

B. Reauthorization

1. Patient does not show evidence of progressive disease while on Zolinza therapy

Authorization will be issued for 12 months.

Examples of systemic therapies include (but are not limited to): • Campath (alemtuzumab) • Cytoxan (cyclophosphamide) • Doxil (pegylated doxorubicin) • Extracorporeal photochemotherapy • Folotyn (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 OncologyTM 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.