Clinical Policy Title:	vorinostat
Policy Number:	RxA.578
Drug(s) Applied:	Zolinza®
Original Policy Date:	03/06/2020
Last Review Date:	8/28/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Cutaneous T-Cell Lymphoma (CTCL) (must meet all)**:**

1. Diagnosis of CTCL;
2. Disease is progressive, persistent or recurrent on or following two systemic therapies (e.g., bexarotene, romidepsin, etc) unless contraindicated or clinically significant adverse effects are experienced.

Approval duration

All Lines of Business (except Medicare): 6 months

II. Continued Therapy Approval

A. Cutaneous T-Cell Lymphoma (CTCL) (must meet all)**:**

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

Approval duration

All Lines of Business (except Medicare): 12 months

References

1. National Comprehensive Cancer Network. Primary Cutaneous Lymphomas Version 3.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/primary_cutaneous.pdf. Accessed August 28, 2024.
2. National Comprehensive Cancer Network. T-Cell Lymphomas Version 4.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/t-cell.pdf. Accessed August 28, 2024.
3. Willemze R, Jaffe ES, Burg G, et al. WHO-EORTC classification for cutaneous lymphomas. Blood. May 2005; 105(10): 3768-85. Available at: https://pubmed.ncbi.nlm.nih.gov/15692063/. Accessed August 28, 2024.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	01/2020	03/06/2020
Policy was reviewed: 1. Clinical Policy Title Table was updated. 2. Drug(s) Applied was updated. 3. Line of Business Policy Applies to was update to all lines of business. 4. Continued Therapy criteria II.A.1 was rephrased to "Currently receiving	10/01/2020	12/07/2020

medication that has been authorized by RxAdvance..." 5. Initial Approval criteria: Commercial and Medicaid approval duration were updated from length of benefit to 6 months. 6. Continued Approval criteria: Commercial and Medicaid approval duration were updated from length of benefit to 12 months. 7. References were updated.		
Policy was reviewed: 1. Continued Therapy Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...". 2. References were reviewed and updated.	10/11/2021	12/07/2021
PA policy was reviewed: 1. Initial Approval Criteria, I.A.2: Updated to include new disease progression criteria Disease is progressive, persistent or recurrent on or following two systemic therapies (e.g., bexarotene, romidepsin, etc) unless contraindicated or clinically significant adverse effects are experienced.	7/28/2022	10/19/2022
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed: 1. Removed age restrictions. 2. Removed prescriber restrictions. 3. Removed dose restrictions. 4. Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days. 5. Removed reauthorization requirement for positive response to therapy. 6. Updated approval duration verbiage. 7. References were reviewed and updated.	8/28/2024	9/13/2024