Clinical Policy: Vorinostat (Zolinza)

Reference Number: CP.PHAR.83
Effective Date: 12.01.12
Last Review Date: 08.22
Line of Business: Commercial, HIM, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Vorinostat (Zolinza®) is a histone deacetylase (HDAC) inhibitor.

FDA Approved Indication(s)

Zolinza is indicated for the 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.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Zolinza is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Diagnosis of CTCL;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. For Zolinza requests; member must use vorinostat, if available, unless contraindicated or clinically significant adverse effects are experienced;
5. Request meets one of the following (a or b):*
   a. Dose does not exceed 400 mg (4 capsules) per day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 6 months
Commercial – 12 months or duration of request, whichever is less

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

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

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Zolinza for CTCL and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Zolinza requests; member must use vorinostat, if available, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 400 mg (4 capsules) per day;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 12 months
Commercial – 12 months or duration of request, whichever is less

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AECTCL: aggressive epidermotropic cutaneous t-cell lymphoma
ATLL: adult t-cell leukemia/lymphoma
ALCL: anaplastic large cell lymphoma
CTCL: cutaneous T-cell lymphoma
EBV: epstein-bar virus
FDA: Food and Drug Administration
HDAC: histone deacetylase
MF: mycosis fungoide
NCCN: National Comprehensive Cancer Network
NHL: non-hodgkin's lymphoma
NK: natural killer
NOS: not otherwise specified
SS: sezary syndrome

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings
None reported

*Appendix D: World Health Organization-European Organization for Research and Treatment of Cancer, 2018 - Classification of CTCL**

- Mycosis fungoides (MF)
  - MF variants and subtypes
    - Folliculotropic MF
    - Pagetoid reticulosis
    - Granulomatous slack skin
- Sezary syndrome (SS)
- Adult T-cell leukemia/lymphoma (ATLL)
- Primary cutaneous CD30+ lymphoproliferative disorders
  - Cutaneous anaplastic large cell lymphoma (ALCL)
  - Lymphomatoid papulosis
- Subcutaneous panniculitis-like T-cell lymphoma
- Extranodal natural killer (NK)**/T-cell lymphoma, nasal type
- Chronic active Epstien-Bar virus (EBV) infection
- Primary cutaneous peripheral T-cell lymphoma, rare subtypes
  - Primary cutaneous gamma-delta T-cell lymphoma
  - Primary cutaneous aggressive epidermotropic CD8+ cytotoxic T-cell lymphoma (CD8+ AECTCL)
  - Primary cutaneous CD4+ small/medium-sized T-cell lymphoproliferative disorder
  - Primary cutaneous acral CD8+ T-cell lymphoma
- Primary cutaneous peripheral T-cell lymphoma, not otherwise specified (NOS)

**Non-Hodgkin's lymphomas (NHLs) include lymphoproliferative disorders originating in B-lymphocytes, T-lymphocytes, and natural killer cells. Cutaneous T-cell lymphomas (CTCLs) are a subset of NHLs characterized by skin involvement and the potential to progress to lymph nodes, blood, and visceral organs. Mycosis fungoides, the most common CTCL, is an extranodal NHL of mature T-cells with primary skin involvement. Sezary syndrome, a less common CTCL, is characterized by significant blood involvement and lymphadenopathy.*
***Extranodal NK-cell lymphoma is considered a CTCL subtype under the policy criteria.*

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CTCL	400 mg PO QD	400 mg/day

VI. Product Availability

Capsule: 100 mg

VII. References

1. Zolinza Prescribing Information. Whitehouse Station, NJ: Merck and Company, Inc.; January 2020. Available from http://www.merck.com/product/usa/pi_circulars/z/zolinza/zolinza_pi.pdf. Accessed April 11, 2022.

2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed April 11, 2022.
3. National Comprehensive Cancer Network. Primary Cutaneous Lymphomas Version 1.2022. Available at: http://www.nccn.org. Accessed April 11, 2022.
4. Willemze R, Cerroni L, Kempf W, et al. The 2018 update of the WHO-EORTC classification for primary cutaneous lymphomas. Blood 2019;133(16):1703-1714.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2018 annual review: policies combined for Commercial and Medicaid lines of business; age and specialist requirements added; continuation of care statement added; NCCN and FDA-approved uses summarized for improved clarity (criteria limited to CTLC diagnosis); references reviewed and updated.	05.08.18	08.18
3Q 2019 annual review: HIM line of business added; no significant changes; references reviewed and updated.	05.14.19	08.19
3Q 2020 annual review: no significant changes; Appendix D subtype classification updated per NCCN/WHO-EORTC 2018; references reviewed and updated.	05.12.20	08.20
3Q 2021 annual review: no significant changes; updated reference for HIM off-label use to HIM.PA.154 (replaces HIM.PHAR.21); references reviewed and updated.	03.18.21	08.21
Added legacy WCG initial approval duration (WCG.CP.PHAR.83 to be retired); added oral oncology generic redirection language.	11.24.21	02.22
Revised approval duration for Commercial line of business from length of benefit to 12 months or duration of request, whichever is less	01.20.22	05.22
3Q 2022 annual review: no significant changes; legacy WCG initial approval duration consolidated to 6 months; references reviewed and updated.	04.11.22	08.22

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering

benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.