Pharmacy Drug Policy & Procedure

Policy Name:	Voxzogo (vosoritide)	Policy#:	3213P

Purpose of the Policy

The purpose of this policy is to define coverage criteria for Voxzogo (vosoritide).

Statement of the Policy

Health Alliance Medical Plans and Health Alliance Northwest will approve the use of Voxzogo (vosoritide) under the specialty pharmacy benefit if the following criteria are met.

Criteria

1. Coverage Criteria

1.1 Diagnosis of achondroplasia confirmed through genetic testing
- Genetic testing must confirm an identifiable mutation in the fibroblast growth factor receptor type 3 (FGFR3) gene
- Diagnosis must be supported by symptoms or imaging tests consistent with a diagnosis of achondroplasia such as enlarged head, prominent forehead, shortened facial bones, shortened long bones with mid-bone abnormalities, etc

1.2 Documentation or imaging to support open epiphyses (open growth plates that should be closed)

1.3 Age <18 years old

1.4 Prescribed by or with a geneticist (gene doctor), skeletal dysplasia specialist, or endocrinologist (endocrine system doctor)

1.5 Documentation of recent growth velocity ≥ 1.5 centimeters/year

1.6 Documentation patient is able to walk and stand without assistance

2. Exclusion Criteria

2.1 Previous treatment with growth hormone or insulin-like growth factor within the past 6 months

2.2 Planned or expected limb lengthening surgery

2.3 Short stature related to a condition other than achondroplasia

3. Approval Period

3.1 Initial: 12 months

3.2 Reauthorization: 12 months when the following criteria has been met:
- Documentation of improved annualized growth velocity compared to baseline
- Documentation or imaging to support open epiphyses

CPT Codes	

HCPCS Codes	

References

1. Voxzogo (vosoritide) [prescribing information]. Novato, CA: BioMarin Pharmaceutical Inc; November 2021.
2. Savarirayan R, Irving M, Bacino CA, et al. C-type natriuretic peptide analogue therapy in children with achondroplasia. N Engl J Med. 2019;381(1):25-35.
3. Kubota T, Adachi M, Kitaoka T, et al. Clinical Practice Guidelines for Achondroplasia. Clin Pediatr Endocrinol. 2020;29(1):25-42.

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DISCLAIMER
This Medical Policy has been developed as a guide for determining medical necessity. The process of medical necessity review also entails review of the most recent literature and physician review. Medical Policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise their medical judgment in providing the most appropriate care. Health Alliance encourages input from providers when developing and implementing medical policies. Benefit determinations are based on applicable contract language in the member's Policy/ Subscription Certificate/ Summary Plan Description. This Medical Policy does not guarantee coverage. There may be a delay between the revision of this policy and the posting on the web. Please contact the Health Alliance Customer Service Department at 1-800-851-3379 for verification of coverage.