STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Services
Prior Authorization Criteria
Voxzogo® (vosoritide)
Prior Authorization Request Form

Voxzogo (vosoritide) is a C-type natriuretic peptide (CNP) analog indicated to increase linear growth in pediatric patients with achondroplasia who are 5 years of age and older with open epiphyses. This indication is approved under accelerated approval based on an improvement in annualized growth velocity. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s).

CRITERIA FOR APPROVAL:

1. The patient must be within the age range as recommended by the FDA label and indication; **AND**
2. The patient must have a documented diagnosis of achondroplasia confirmed with genetic testing; **AND**
3. Voxzogo must be prescribed by a pediatric endocrinologist; **AND**
4. There is confirmation of non-closure of epiphyseal plates (x-ray determining bone age) must be provided for females > age 12 and males > 14; **AND**
5. The height, body weight, growth velocity, and physical development of the patient will be measured at baseline and will also be monitored and assessed throughout therapy; **AND**
6. Patient has not had (within the previous 18 months) nor will they receive limb-lengthening surgery during treatment with Voxzogo; **AND**
7. Voxzogo will not be used in combination with any human growth hormone products.

Approval Duration: Initial approval will be for 3 months.

Criteria for reauthorization:

1. Demonstrate continued documented compliance; **AND**
2. The patient does not have closure of epiphyses; **AND**
3. Documentation of improvement in growth velocity compared to pre-treatment baseline has been provided.

Continuation of therapy will be granted for 12 months.

DUR Board Approval: 9/28/2022