| Field Name | Field Description |
|---|---|
| Prior Authorization Group Description | Natriuretic Peptides for Achondroplasia |
| Drugs | Voxzogo (vosoritide) |
| Covered Uses | Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines. |
| Exclusion Criteria | Hypochondroplasia or short stature condition other than achondroplasia |
| Required Medical Information | See "Other Criteria" |
| Age Restrictions | According to FDA approved prescribing information |
| Prescriber Restrictions | Prescribed by, or in consultation with, an endocrinologist, medical geneticist, or other specialist for the treatment of achondroplasia |
| Coverage Duration | If all of the criteria are met, the initial request will be approved for 6 months. For continuation of therapy, the request will be approved for 12 months. |
| Other Criteria<br><br>Revision/Review Date: 4/2023 | **Initial Authorization:**<br>• Member has a diagnosis of achondroplasia as confirmed via genetic testing<br>• Prescriber attests patient has open epiphyses<br>• Documentation is provided of baseline recent (within the past 6 months) growth velocity ≥1.5 cm/year<br>• Medication is prescribed at an FDA approved dose<br><br>**Re-Authorization:**<br>• Documentation of positive clinical response to therapy (as demonstrated by improvement over baseline in annualized growth velocity)<br>• Prescriber attests patient has open epiphyses<br>• Medication is prescribed at an FDA approved dose<br><br>**If all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.** |