Effective date: 05/01/2022
Review date: 2/2022, 3/2023, 2/2024, 4/2025, 08/2026 Scope: Medicaid

Voxzogo (vosoritide)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met, and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication
To increase linear growth in pediatric patients with achondroplasia 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).

All other indications are considered experimental/investigational and not medically necessary.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 6 months may be granted for treatment of achondroplasia in pediatric members when ALL of the following criteria are met:

A. Prescriber is an endocrinologist, pediatric endocrinologist, geneticist, or neurologist.
B. Documentation that diagnosis of achondroplasia was confirmed by genetic testing for FGFR3 mutation.
C. Documentation of recent annualized growth velocity (AGV).
D. Recent documentation showing that the member has open epiphyses and a current AGV of greater than or equal to 1.5cm/year.
E. Documentation that the member has not received growth hormone, insulin-like growth factor 1 or anabolic steroids in the past 6 months.
F. Documentation that the member does not have planned or expected limb lengthening surgery. (Previous limb-lengthening surgery must have occurred at least 18 months prior to administration of Voxzogo).
G. Member is not using Voxzogo in combination with Yuviwel.

III. CONTINUATION OF THERAPY

Authorization of 6 months may be granted for continuation of therapy in pediatric members when all of the following criteria are met:

A. Chart note documentation showing that the member has both:
    1. Open epiphyses AND
    2. A current AGV of greater than or equal to 1.5cm/year

IV. QUANTITY LIMIT

a. Voxzogo 0.4mg, 0.56mg, 1.2mg: 1 vial per day

Effective date: 05/01/2022
Review date: 2/2022, 3/2023, 2/2024, 4/2025, 08/2026 Scope: Medicaid

V. REFERENCES

1. Voxzogo [package insert]. Novato, CA: BioMarin Pharmaceutical Inc.; November 2024. Accessed March 2025.
2. Kubota T, Adachi M, Kitaoka T, Hasegawa K, Ohata Y, Fujiwara M, Michigami T, Mochizuki H, Ozono K. Clinical Practice Guidelines for Achondroplasia. Clin Pediatr Endocrinol. 2020;29(1):25-42.
3. Tracy L. Trotter, Judith G. Hall, and the Committee on Genetics. Health Supervision for Children with Achondroplasia. Pediatrics. 2005; 116 (3): 771–783.