Reference number(s)
6582-A

Specialty Guideline Management Voranigo

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Voranigo	vorasidenib

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 Indications

Voranigo is indicated for the treatment of adult and pediatric patients 12 years and older with Grade 2 astrocytoma or oligodendroglioma with a susceptible IDH1 or IDH2 mutation, following surgery including biopsy, sub-total resection, or gross total resection.

Compendial Uses

Recurrent or progressive IDH1 or IDH2 mutated WHO grade 2 astrocytoma or oligodendroglioma

Adjuvant treatment of IDH1 or IDH2 mutated WHO grade 2 astrocytoma or oligodendroglioma with Karnofsky Performance Status (KPS) less than 60

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

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Documentation

Submission of the following information is necessary to initiate the prior authorization review: medical record documentation of isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation.

Coverage Criteria

Astrocytoma and Oligodendroglioma

Authorization of 12 months may be granted for the treatment of members 12 years of age and older with Grade 2 astrocytoma or oligodendroglioma with a susceptible IDH1 or IDH2 mutation, when any of the following is met:

- The requested medication will be used following surgery, including biopsy, sub-total resection, or gross total resection, or
- The requested medication will be used as adjuvant treatment as a single agent and member has a Karnofsky Performance Status (KPS) less than 60, or
- The member has progressive or recurrent disease and the requested medication will be used as a single agent.

Continuation of Therapy

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria section when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

References

1. Voranigo [package insert]. Boston, MA: Servier Pharmaceuticals LLC.; August 2024.
2. The The NCCN Drugs & Biologics Compendium® © 2024 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed October 9, 2024.