Reference number(s)
1863 – A

Specialty Guideline Management
Zolinza

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
Zolinza	vorinostat

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[1]

Zolinza is indicated for the treatment of cutaneous manifestations in patients with cutaneous T-cell lymphoma (CTCL) who have progressive, persistent, or recurrent disease on or following two systemic therapies

Compendial Uses[2]

Mycosis fungoides (MF)/Sézary syndrome (SS)

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

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Coverage Criteria

Cutaneous T-cell Lymphoma (CTCL)[1-2]

Authorization of 12 months may be granted for the treatment of CTCL (e.g., MF, SS).

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. Zolinza [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; July 2022.
2. The NCCN Drugs & Biologics Compendium® © 2024 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed December 16, 2024