Reference number(s)
6582-A

SPECIALTY GUIDELINE MANAGEMENT

VORANIGO (vorasidenib)

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 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.

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

II. 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.

III. CRITERIA FOR INITIAL APPROVAL

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, following surgery including biopsy, sub-total resection, or gross total resection.

IV. CONTINUATION OF THERAPY

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

V. REFERENCES

1. Voranigo [package insert]. Boston, MA: Servier Pharmaceuticals LLC.; August 2024.