Custom Criteria for
BlueCross Blue Shield of Rhode Island Commercial

ZOLINZA (vorinostat)

GPI CODING:

215315750001**

DESCRIPTION:

Vorinostat is a histone deacetylase (HDAC) inhibitor indicated for the treatment of cutaneous manifestations in patients with cutaneous T-cell lymphoma who have progressive, persistent or recurrent disease on or following two systemic therapies.

APPROVAL DURATION:

Approval duration: 1 year

CRITERIA FOR ZOLINZA

I. Patient has a diagnosis of cutaneous T-cell lymphoma with cutaneous manisfestations **OR**
II. Off label uses for oncology drugs if considered medically acceptable in one or more of the following compendia (i.e., Micromedex DrugDex, AHFS, Clinical Pharmacology, and NCCN.) A use is identified by a compendium as medically accepted if the:
   A. Indication is a Category 1 or 2A in NCCN,
   B. Indication is a Class I, Class IIa or Class IIb in DrugDex,
   C. Narrative text in AHFS or Clinical Pharmacology is supportive; or
   D. The use is supported by clinical research in 2 or more peer-reviewed medical journals

AND

III. Patient has progressive, persistent or recurrent disease on or following 2 systemic therapies (e.g., chemotherapy, retinoids, interferons)