UnitedHealthcare

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1381-5
Program	Prior Authorization/Notification
Medication	Voxzogo™ (vosoritide)
P&T Approval Date	3/2022, 3/2023, 12/2023, 12/2024, 12/2025
Effective Date	3/1/2026

1. Background:

Voxzogo (vosoritide) is a C type natriuretic peptide (CNP) analog indicated 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).

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Voxzogo** will be approved based on **all** of the following criteria:

    a. Diagnosis of achondroplasia

    -AND-

    b. Patient is less than 18 years of age

    -AND-

    c. Patient has open epiphyses

    Authorization will be issued for 12 months

B. Reauthorization

1. **Voxzogo** will be approved based on the following criterion:

    a. Documentation of positive clinical response to Voxvogo therapy

    -AND-

    b. Patient has open epiphyses

    Authorization will be issued for 12 months

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

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3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits and medical necessity may be in place.

4. References:

1. Voxzogo [package insert]. Novato, CA: BioMarin Pharmaceutical Inc.; November 2024.

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Change Control	
3/2022	New program
3/2023	Annual review with no changes to coverage criteria. Added state mandate footnote.
12/2023	Updated background and coverage criteria with expanded indication in pediatric patients of all ages. Updated reference.
12/2024	Annual review. Added requirement that patient has open epiphyses to reauthorization criteria.
12/2025	Annual review with no changes to coverage criteria. Updated references.

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