Zolinza (vorinostat)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	1 year

Medications	Quantity Limit
Zolinza (vorinostat)	May be subject to quantity limit

APPROVAL CRITERIA

Requests for Zolinza (vorinostat) may be approved if the following criteria are met:

I. Cutaneous T-cell lymphoma; **AND**
   A. Individual has progressive, persistent, or recurrent disease on or following two prior therapies;

OR

II. Non-Hodgkin Lymphoma - Mycosis fungoides (MF)/Sézary Syndrome (SS) (NCCN 2A).

State Specific Mandates		
State name N/A	Date effective N/A	Mandate details (including specific bill if applicable) N/A

Key References:

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2017. URL: http://www.clinicalpharmacology.com. Updated periodically.

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DrugPoints® System [Internet Database]. Greenwood Village, CO: Thomson Reuters (Healthcare) Inc. Updated periodically.

Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2017; Updated periodically.

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