

Field Name	Field Description
Prior Authorization Group Description	Natriuretic Peptides for Achondroplasia
Drugs	Voxzogo (vosoritide)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Hypochondroplasia or short stature condition other than achondroplasia
Required Medical Information	See “Other Criteria”
Age Restrictions	According to FDA approved prescribing information
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist, medical geneticist, or other specialist for the treatment of achondroplasia
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For continuation of therapy, the request will be approved for 12 months.
Other Criteria	<p><u>Initial Authorization:</u></p> <ul style="list-style-type: none"> • Member has a diagnosis of achondroplasia as confirmed via genetic testing • Prescriber attests patient has open epiphyses • Documentation of baseline growth velocity • Medication is prescribed at an FDA approved dose <p><u>Re-Authorization:</u></p> <ul style="list-style-type: none"> • Documentation of positive clinical response to therapy (as demonstrated by improvement over baseline in annualized growth velocity) • Prescriber attests patient has open epiphyses • Medication is prescribed at an FDA approved dose
Revision/Review Date: 4/2025	If all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.