Clinical Policy: Vorinostat (Zolinza)

Reference Number: CP.PHAR.83
Effective Date: 12.01.12
Last Review Date: 08.26
Line of Business: Commercial, HIM/ICHRA, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Vorinostat (Zolinza®) is a histone deacetylase (HDAC) inhibitor.

FDA Approved Indication(s)

Zolinza is indicated for the treatment of cutaneous manifestations in patients with cutaneous T-cell lymphoma (CTCL) who have progressive, persistent, or recurrent disease on or following two systemic therapies.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Zolinza is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Cutaneous T-Cell Lymphoma (must meet all)**:**

1. Diagnosis of CTCL (*see Appendix D for subtypes*);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. For Zolinza requests, member must use vorinostat, if available, unless contraindicated or clinically significant adverse effects are experienced;
5. Request meets one of the following (a or b):*
   a. Dose does not exceed 400 mg (4 capsules) per day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 12 months or duration of request, whichever is less

B. Hodgkin Lymphoma (off-label) (must meet all)**:**

1. Diagnosis of classic Hodgkin lymphoma;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. For Zolinza requests, member must use vorinostat, if available, unless contraindicated or clinically significant adverse effects are experienced;

5. Disease is refractory to at least 3 prior lines of subsequent therapy (*see Appendix B*);
6. Prescribed in combination with Keytruda®;*
   **Prior authorization may be required for Keytruda*
7. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).
   **Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 12 months or duration of request, whichever is less

C. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Zolinza for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Zolinza requests, member must use vorinostat, if available, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, request meets one of the following (a or b):*
   a. CTCL only: New dose does not exceed 400 mg (4 capsules) per day;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.
   **Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 12 months or duration of request, whichever is less

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AECTCL: aggressive epidermotropic cutaneous t-cell lymphoma
ATLL: adult t-cell leukemia/lymphoma
ALCL: anaplastic large cell lymphoma
CTCL: cutaneous T-cell lymphoma
EBV: Epstein-Bar virus
FDA: Food and Drug Administration
HDAC: histone deacetylase
MF: mycosis fungoides
NCCN: National Comprehensive Cancer Network
NHL: non-Hodgkin's lymphoma
NK: natural killer
NOS: not otherwise specified
SS: Sezary syndrome

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Examples of Primary Systemic Therapy Regimens for Hodgkin Lymphoma		
• ABVD (doxorubicin, bleomycin, vinblastine, and dacarbazine) ± involved site radiation therapy (ISRT) • ABVD followed by BrECADD (brentuximab vedotin [BV], etoposide, cyclophosphamide, doxorubicin,	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
dacarbazine, dexamethasone) + granulocyte-colony stimulating factor (G-CSF) ± ISRT • BrECADD + G-CSF ± ISRT • BV-AVD (doxorubicin, vinblastine, and dacarbazine) + G-CSF • Nivolumab-AVD		
Examples of Second Line and Subsequent Therapy Regimens for Hodgkin Lymphoma		
• BV-nivolumab • GVD (gemcitabine, vinorelbine, liposomal doxorubicin) • GVD-pembrolizumab • ICE (ifosfamide, carboplatin, etoposide) • ICE-nivolumab • ICE-pembrolizumab • BV • BV-bendamustine • DHAP (dexamethasone, cisplatin, high-dose cytarabine) • Gemcitabine/bendamustine/vinorelbine • ICE-BV • IGEV (ifosfamide, gemcitabine, vinorelbine)	Varies	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings
None reported

*Appendix D: World Health Organization-European Organization for Research and Treatment of Cancer, 2018 – Classification of CTCL**

- Mycosis fungoides (MF)
  - MF variants and subtypes
    - Folliculotropic MF
    - Pagetoid reticulosis
    - Granulomatous slack skin
- Sezary syndrome (SS)
- Adult T-cell leukemia/lymphoma (ATLL)
- Primary cutaneous CD30+ lymphoproliferative disorders
  - Cutaneous anaplastic large cell lymphoma (ALCL)
  - Lymphomatoid papulosis
- Subcutaneous panniculitis-like T-cell lymphoma
- Extranodal natural killer (NK)**/T-cell lymphoma, nasal type
- Chronic active Epstien-Bar virus (EBV) infection
- Primary cutaneous peripheral T-cell lymphoma, rare subtypes

- Primary cutaneous gamma-delta T-cell lymphoma
- Primary cutaneous aggressive epidermotropic CD8+ cytotoxic T-cell lymphoma (CD8+ AECTCL)
- Primary cutaneous CD4+ small/medium-sized T-cell lymphoproliferative disorder
- Primary cutaneous acral CD8+ T-cell lymphoma

- Primary cutaneous peripheral T-cell lymphoma, not otherwise specified (NOS)

Non-Hodgkin's lymphomas (NHLs) include lymphoproliferative disorders originating in B-lymphocytes, T-lymphocytes, and natural killer cells. Cutaneous T-cell lymphomas (CTCLs) are a subset of NHLs characterized by skin involvement and the potential to progress to lymph nodes, blood, and visceral organs. Mycosis fungoides, the most common CTCL, is an extranodal NHL of mature T-cells with primary skin involvement. Sezary syndrome, a less common CTCL, is characterized by significant blood involvement and lymphadenopathy.
***Extranodal NK-cell lymphoma is considered a CTCL subtype under the policy criteria.*

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CTCL	400 mg PO QD	400 mg/day

VI. Product Availability

Capsule: 100 mg

VII. References

1. Zolinza Prescribing Information. Whitehouse Station, NJ: Merck and Company, Inc.; July 2022. Available from http://www.zolinza.com. Accessed April 17, 2026.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed April 28, 2026.
3. National Comprehensive Cancer Network. Cutaneous Lymphomas Version 2.2026. Available at: http://www.nccn.org. Accessed April 29, 2026.
4. National Comprehensive Cancer Network. Hodgkin Lymphoma Version 1.2026. Available at: http://www.nccn.org. Accessed April 29, 2026.
5. Willemze R, Cerroni L, Kempf W, et al. The 2018 update of the WHO-EORTC classification for primary cutaneous lymphomas. Blood 2019;133(16):1703-1714.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2022 annual review: no significant changes; legacy WCG initial approval duration consolidated to 6 months; references reviewed and updated.	04.11.22	08.22
Template changes applied to other diagnoses/indications.	10.12.22	
3Q 2023 annual review: no significant changes; references reviewed and updated.	04.14.23	08.23
3Q 2024 annual review: no significant changes; references reviewed and updated.	05.16.24	08.24
3Q 2025 annual review: added off-label criteria for use in Hodgkin lymphoma per NCCN; references reviewed and updated.	05.06.25	08.25

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2026 annual review: added ICHRA line of business; for all indications, extended initial approval duration for Medicaid and HIM from 6 to 12 months; references reviewed and updated.	04.29.26	08.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.