Clinical Policy: Vorasidenib (Voranigo)

Reference Number: CP.PHAR.699
Effective Date: 12.01.24
Last Review Date: 11.26
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

Vorasidenib (Voranigo®) is an isocitrate dehydrogenase-1 (IDH1) and isocitrate dehydrogenase-2 (IDH2) inhibitor.

FDA Approved Indication(s)

Voranigo is indicated for the treatment of adult and pediatric patients 12 years and older with Grade 2 astrocytoma or oligodendroglioma with a susceptible IDH1 or IDH2 mutation, as detected by an FDA-approved test, following surgery including biopsy, sub-total resection, or gross total resection.

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 Voranigo is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Glioma (must meet all)**:**

1. Diagnosis of astrocytoma, oligodendroglioma, or other high-grade glioma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 12 years;
4. Disease is positive for an IDH1 or IDH2 mutation;
5. Glioma is one of the following (a, b, or c):
   a. World Health Organization (WHO) grade 2 (i.e., a low-grade), and one of the following (i, ii, or iii):
      i. Member has received surgery including biopsy, sub-total resection, or gross total resection;
      ii. Disease is recurrent or progressive after radiation therapy and chemotherapy;
      iii. Member has poor performance status (Karnofsky Performance Status [KPS] < 60);
   b. WHO grade 3 (astrocytoma or oligodendroglioma) or 4 (astrocytoma only), and prescribed in one of the following ways (i or ii):
      i. As adjuvant therapy;
      ii. For disease that is recurrent or progressive;

c. Other high-grade glioma (i.e., H3-mutated high-grade glioma, high-grade astrocytoma with piloid features [HGAP], or pleomorphic xanthoastrocytoma [PXA] WHO grade 3), and disease is recurrent or progressive;

6. Prescribed as a single agent;
7. For Voranigo requests, member must use vorasidenib, if available, unless contraindicated or clinically significant adverse effects are experienced;
8. Request meets one of the following (a, b, or c):*
   a. For adults and pediatric members with body weight ≥ 40 kg: Dose does not exceed both of the following (i and ii):
      i. 40 mg per day;
      ii. 1 tablet per day;
   b. For pediatric members with body weight < 40 kg: Dose does not exceed both of the following (i and ii):
      i. 20 mg per day;
      ii. 2 tablets per day;
   c. 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: 12 months

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.

II. Continued Therapy

A. Glioma (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Voranigo for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Voranigo requests, member must use vorasidenib, if available, unless contraindicated or clinically significant adverse effects are experienced;
4. Prescribed as a single agent;

5. If request is for a dose increase, request meets one of the following (a, b, or c):*
   a. For adults and pediatric members with body weight ≥ 40 kg: Dose does not exceed both of the following (i and ii):
      i. 40 mg per day;
      ii. 1 tablet per day;
   b. For pediatric members with body weight < 40 kg: Dose does not exceed both of the following (i and ii):
      i. 20 mg per day;
      ii. 2 tablets per day;
   c. 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: 12 months

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

FDA: Food and Drug Administration
HGAP: high-grade astrocytoma with piloid features
IDH: isocitrate dehydrogenase
KPS: Karnofsky Performance Status
NCCN: National Comprehensive Cancer Network
PXA: pleomorphic xanthoastrocytoma
WHO: World Health Organization

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
None reported

Appendix D: General Information
Information on FDA-approved tests for detection of IDH1 or IDH2 mutations in Grade 2 astrocytoma or oligodendroglioma for selecting patients for treatment with Voranigo is available at: https://www.fda.gov/CompanionDiagnostics.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Astrocytoma or oligodendroglioma	Adults: 40 mg PO QD Pediatric members ≥ 12 years: • Body weight ≥ 40 kg: 40 mg PO QD • Body weight < 40 kg: 20 mg PO QD	40 mg/day

VI. Product Availability
Oral tablets: 10 mg, 40 mg

VII. References
1. Voranigo Prescribing Information. Boston, MA: Servier Pharmaceuticals, LLC.; June 2026. Available at: https://www.voranigo.com. Accessed July 8, 2026.
2. National Comprehensive Cancer Network. Central Nervous System Cancers Version 1.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cns.pdf. Accessed August 18, 2026.
3. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed August 18, 2026.
4. Mellinghoff IK, van den Bent MJ, Blumenthal DT, et al. Vorasidenib in IDH1- or IDH2-mutant low-grade glioma. N Engl J Med. 2023;389(7):589-601.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	08.26.24	11.24
RT4: updated FDA Approved Indication(s) section to include "as detected by an FDA-approved test" per updated PI; added Appendix D with link for information on FDA-approved tests for detection of IDH1 or IDH2 mutations in Grade 2 astrocytoma or oligodendroglioma; added additional uses for Grade 2 disease as well as coverage for Grade 3 and 4 disease per NCCN.	04.17.25	
4Q 2025 annual review: added indication of other high-grade glioma per NCCN; for WHO grade 3 and 4 disease, removed criterion for poor KPS and added option for use as adjuvant therapy	07.07.25	11.25

Reviews, Revisions, and Approvals	Date	P&T Approval Date
per NCCN; revised initial approval duration to 12 months; references reviewed and updated.		
4Q 2026 annual review: added monotherapy requirement to continued therapy; added ICHRA line of business; references reviewed and updated.	07.08.26	11.26

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.

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