AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Voxzogo		Page:	
Effective Date:	5/18/2026		Last Review Date:	4/2026
Applies to:	☒Illinois ☒New Jersey ☒Pennsylvania Kids	☐Florida ☒Maryland ☐Virginia	☒Florida Kids ☐Michigan ☐KY PRMD	

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Voxzogo under the patient's prescription drug benefit.

Description:

FDA-Approved Indications[1]

Voxzogo is 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).

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Voxzogo

Policy/Guideline:

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

- Chart notes or documentation of symptoms (i.e., short stature with marked shortening of extremities due to rhizomelia, a characteristic facial configuration, trident hand) (if applicable)
- Laboratory report of X-ray findings consistent with achondroplasia or laboratory report of genetic testing for FGFR3 mutation
- Growth chart
- For continuation requests: Chart notes or medical record documentation confirming benefit from therapy (e.g., growth chart showing improvement or stabilization of annualized growth velocity [centimeters per year])

Prescriber Specialties

This medication must be prescribed by or in consultation with an endocrinologist, pediatric endocrinologist, geneticist, or neurologist.

Coverage Criteria

Achondroplasia

Authorization of 12 months may be granted for treatment of achondroplasia when BOTH of the following criteria are met:

- The diagnosis of achondroplasia was confirmed by EITHER of the following:
  - Symptoms (i.e., short stature with marked shortening of extremities due to rhizomelia, a characteristic facial configuration, trident hand) AND X-ray findings consistent with achondroplasia
  - Genetic testing for FGFR3 mutation
- Epiphyses are open

Continuation of Therapy

Authorization of 12 months may be granted for continuation of therapy when BOTH of the following criteria are met:

- Member meets all requirements in the coverage criteria
- Member is experiencing benefit from therapy (e.g., improvement or stabilization of annualized growth velocity [centimeters per year] from baseline)

Approval Duration and Quantity Restrictions:

Approval:

- Initial: 12 months; renewal: 12 months

Quantity Limits:

- Voxzogo (vosoritide) single-dose vial 0.4 mg: 30 per 30 days
- Voxzogo (vosoritide) single-dose vial 0.56 mg: 30 per 30 days
- Voxzogo (vosoritide) single-dose vial 1.2 mg: 30 per 30 days

References:

1. Voxzogo [package insert]. Novato, CA: BioMarin Pharmaceutical Inc.; November 2024.
2. Kubota T, Adachi M, Kitaoka T, et al. Clinical Practice Guidelines for Achondroplasia. Clin Pediatr Endocrinol. 2020;29(1):25-42.
3. Trotter TL, Hall JG, American Academy of Pediatrics Committee on Genetics. Health supervision for children with achondroplasia. Pediatrics. 2005;116(3):771–783.
4. Hoover-Fong J, Scott CI, Jones MC, Committee on Genetics. Health supervision for people with achondroplasia. Pediatrics. 2020;145(6):e20201010.