

**Zolinza®** (*vorinostat*)

**FDA-APPROVED INDICATION**

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 2 systemic therapies.

**COVERAGE POLICY**

Zolinza is covered for members who meet the following criteria:

- A. Covered for cutaneous manifestations of CTCL after trial/failure of a minimum of two systemic treatments, one of which must be Targretin, unless contraindicated.

**DOSE**

The recommended dose of Zolinza is 400 mg orally once daily with food.

**Quantity limit: 120 capsules/month.**

**NON COVERAGE**

Zolinza is NOT covered for members with the following criteria:

- A. Usage in non-FDA approved indications are considered experimental/ investigational, and therefore NOT covered.

**REFERENCES**

1. Zolinza® (vorinostat) prescribing information. Merck & Co., Inc., 2006.  
[http://www.merck.com/product/usa/pi\\_circulars/z/zolinza/zolinza\\_pi.pdf](http://www.merck.com/product/usa/pi_circulars/z/zolinza/zolinza_pi.pdf)
2. Whittaker SJ, Marsden JR, Spittle M, Russell Jones R. Joint British Association of Dermatologists and U.K. Cutaneous Lymphoma Group guidelines for the management of primary cutaneous T-cell lymphomas. Br J Dermatol 2003 Dec;149(6):1095-107.
3. NCCN Clinical Practice Guidelines. Non-Hodkin's Lymphomas. V.2.2007. June 2007. Accessed July 30<sup>th</sup>, 2007 at [http://www.nccn.org/professionals/physician\\_gls/PDF/nhl.pdf](http://www.nccn.org/professionals/physician_gls/PDF/nhl.pdf)