iowa total care | Iowa Health Link Iowa HHS | Hawki Iowa HHS

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
Vonoprazan (Voquezna)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for vonoprazan (Voquenzna), Voquezna Dual Pak, and Voquezna Triple Pak. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. **Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and**
2. **Patient has a diagnosis of healing of erosive esophagitis (attach endoscopy results for initial diagnosis), maintenance of healed erosive esophagitis (attach endoscopy results for initial diagnosis), and relief of heartburn associated with non-erosive gastroesophageal reflux disease (GERD); and**
    a. **Documentation of an 8-week trial and therapy failure, based on ongoing symptoms, with two preferred PPIs, each twice-daily dosing; or**
3. **Patient has active *Helicobacter pylori (H.pylori)* infection (attach documentation); and**
    a. **Patient has documentation of a recent trial and therapy failure with a preferred agent(s) for the treatment of *H. pylori* infection; and**
    b. **Request is for the triple pak or dual pak.**

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

If the criteria for coverage are met, requests will be evaluated for the dosage and duration of therapy according to the indications specified on the FDA approved label.

Non-Preferred

☐ Voquezna ☐ Voquezna Dual Pak ☐ Voquezna Triple Pak

Strength	Usage Instructions	Quantity	Day's Supply
_____	_____	_____	_____

Diagnosis (attach documentation): _____

Healing of erosive esophagitis, Maintenance of healed erosive esophagitis, Relief of heartburn associated with non-erosive GERD:

Preferred PPI Trial 1:

Name/dose:_____ Trial dates:_____

Failure reason/medical contraindication: _____

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Preferred PPI Trial 2:

Name/dose:_____ Trial dates:_____

Failure reason/medical contraindication: _____

Active *H. pylori* infection:

Trial of preferred agent:

Name/dose:_____ Trial dates:_____

Failure reason/medical contraindication: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*