US Family Health Plan
Prior Authorization Request Form for
Vonoprazan (Voquezna)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization expires in 6 months for initial approval, then annually.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Voquezna.*	☐ Yes (subject to verification) Proceed to question **2**	☐ No Proceed to question **5**
2. Provider acknowledges that current FDA labeling recommends up to 6-months of maintenance therapy with the requested medication.	☐ Acknowledged Proceed to question **3**	
3. Has the patient had serious adverse events with the requested medication?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **4**
4. Has the provider considered step-down therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
5. Prescriber acknowledges that omeprazole capsules and pantoprazole tablets are the Department of Defense's preferred Proton Pump Inhibitors (PPIs) and are available without a prior authorization.	☐ Acknowledged Proceed to question **6**	
6. Is the patient 18 years of age or older?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

7. Is the prescription written by or in consultation with a gastroenterologist or infectious disease specialist?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Will the requested medication be used concomitantly with a Proton Pump Inhibitor (PPI)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **9**
9. What is the diagnosis or indication?	☐ erosive esophagitis **-** Proceed to question **10** ☐ Helicobacter pylori (H. pylori) infection **-** Proceed to question **14** ☐ Other **– STOP Coverage not approved**	
10. Does the patient have Los Angeles Grade C or D esophagitis?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Does the patient have a contraindication to ALL of the following: omeprazole, pantoprazole, rabeprazole, esomeprazole, and lansoprazole?	☐ Yes **Sign and date below**	☐ No Proceed to question **12**
12. Has the patient had an inadequate response after an adequate 8-week trial (high-dose, twice daily dosing, administered 30-60 minutes before meals) or adverse reaction to at least TWO of the following formulary PPIs: ONE must be omeprazole, pantoprazole, esomeprazole, or lansoprazole and the OTHER must be rabeprazole?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Please provide the drug name, strength, frequency, and date for two PPI trials. ***Note: The drug names, strengths, frequency, and dates of therapy for each medication must be provided or your case could be denied.*** **Drug name _____ Strength_____ Frequency_____ Date_____** **Drug name _____ Strength_____ Frequency_____ Date_____** **Sign and date below**		
14. Has the patient tried and failed two 14-day trials with a guideline-recommended first-line treatment regimen? Appropriate treatment combinations for *H. pylori* include PPIs, amoxicillin, rifabutin, clarithromycin, bismuth subsalicylate, metronidazole, tetracycline, and levofloxacin.	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date