

VOQUEZNA DUAL PAK & TRIPLE PAK (vonoprazan fumarate/amoxicillin trihydrate/clarithromycin)

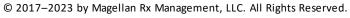


Prior Authorization Request Form

Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME:		_ MEMBER'S FIRST N	MEMBER'S FIRST NAME:		
	, chart notes or lab data, to	, ,	any additional documentation that is ion request). Information contained in		
			☐ URGENT		
MEMBER INFORMATION					
LAST NAME:		FIRST NAME:			
PHONE NUMBER:		DATE OF BIRTH:			
STREET ADDRESS:					
CITY:		STATE: Z	STATE: ZIP CODE:		
PATIENT INSURANCE ID NUI	MBER:				
MALE FEMALE HEIGHT OR THE PRESCRIPTION OF THE	IBER, YOU WILL NEED TO SUBMIT A PHI DIS M/MEMBER/EXTERNAL/COMMERCIAL/CO	SCLOSURE AUTHORIZATION FORM W DMMON/DOC/EN-US/PHI_DISCLOSE E):	VITH THIS REQUEST WHICH CAN BE FOUND AT THE SURE AUTHORIZATION.PDF		
PRESCRIBER INFORMATION					
LAST NAME:		FIRST NAME:	FIRST NAME:		
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:	EMAIL ADDRESS:		
NPI NUMBER:		DEA NUMBER:	DEA NUMBER:		
PHONE NUMBER:		FAX NUMBER:			
STREET ADDRESS:					
CITY:		STATE: ZIP CODE:			
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSON:			
MEDICATION OR MEDICAL	DISPENSING INFORMATIO	N			
MEDICATION NAME:					
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:		
■ NEW THERAPY DURATION OF THERAPY (SPE	RENEWAL ECIFIC DATES):	IF RENEWAL: DATE	THERAPY INITIATED:		

Continued on next page.



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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:			
1. HAS THE PATIENT TRIED ANY OTHE	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:		
2. LIST DIAGNOSES:		ICD-10:		
☐ H. pylori☐ Other diagnosis:	ICD-10			
PRIOR AUTHORIZATION.	N: PLEASE PROVIDE ALL RELEVANT CLIN	CAL INFORMATION TO SUPPORT A		
Clinical Information: Is the drug going to be used in conju	nction with a clinical trial? Yes No			
Is the request for Voquezna combination packs with amoxicillin or amoxicillin and clarithromycin? Yes No				
•	obacter pylori (H. pylori) infection as co biopsy or stool antigen test? (documen			
Is Voquezna being used as second line therapy tried)? ☐ Yes ☐ No	due to resistant or persistent H. pylori	(documentation required of dates and		
Has patient had previous treatment w ☐ Yes ☐ No	rith Pylera, Talicia or Voquezna? (docun	nentation and dates must be provided)		
Are there any other comments, diagn physician feels is important to this re	oses, symptoms, medications tried or fa view?	iled, and/or any other information the		
*Please note: Not all drugs/diagnoses information is received.	are covered on all plans. This request m	ay be denied unless all required		
the Health Plan, insurer, Medical Grou	n provided is true and accurate to the be p or its designees may perform a routine curacy of the information reported on th	e audit and request the medical		
Prescriber Signature or Electronic I.D.	Verification:	Date:		
you are not the intended recipient, you are her	ompanying this transmission contain confidential eby notified that any disclosure, copying, distribu have received this information in error, please	tion, or action taken in reliance on the contents		

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and arrange for the return or destruction of these documents.

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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811

St. Paul, MN 55164-0811



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