Voquezna Tablets (vonoprazan)
Prior Authorization Request Form

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

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI 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 INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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1. HAS THE PATIENT TRIED ANY OTHER 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:**
☐ Erosive Esophagitis(EE) ☐ Other diagnosis: _____ ICD-10 Code(s):	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is patient going to be using drug in a clinical trial? ☐ Yes ☐ No

Is request only for the 10mg or 20mg tablets? ☐ Yes ☐ No (Voquezna combination packs with amoxicillin or amoxicillin and clarithromycin not allowed.)

For initial request :

Is prescriber a gastroenterologist or allergist? ☐ Yes ☐ No

Has patient had an 8-week trial with the highest dose tolerated of a proton-pump inhibitor(PPI)? ☐ Yes ☐ No *Please Provide Documentation.*

Does patient have a diagnosis of Erosive Esophagitis? ☐ Yes ☐ No *Copy of endoscopy report verifying diagnosis required.*

Does patient have a diagnosis of Barrett's esophagus or Zollinger-Ellison syndrome or other gastric acid hypersecretory condition? ☐ Yes ☐ No

Is the patient negative for Helicobacter pylori (H. pylori)? ☐ Yes ☐ No *Please Provide Documentation.*

Has the patient had an H. Pylori infection within 45 days of starting Voquezna(vonoprazan)? ☐ Yes ☐ No

Does patient have any other condition affecting the esophagus, including eosinophilic esophagitis; esophageal varices; viral or fungal infection; esophageal stricture? ☐ Yes ☐ No *Please Provide Documentation.*

Does patient have a history of radiation therapy, radiofrequency ablation, endoscopic mucosal resection, or cryotherapy to the esophagus? ☐ Yes ☐ No *Please Provide Documentation.*

Does patient have any history of caustic or physiochemical trauma (including sclerotherapy or esophageal variceal band ligation)? ☐ Yes ☐ No *Please Provide Documentation.* (However, participants diagnosed with Schatzki's ring (mucosal tissue ring around lower esophageal sphincter) are eligible to participate.)

Does the patient have scleroderma (systemic sclerosis)? ☐ Yes ☐ No *Please Provide Documentation.*

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Does the patient have a history of surgery or endoscopic treatment affecting gastroesophageal reflux, including fundoplication and dilation for esophageal stricture (except Schatzki's ring) or a history of gastric or duodenal surgery (except endoscopic removal of benign polyps)? □ Yes □ No *Please Provide Documentation.*

Does the patient have systemic or cutaneous lupus erythematosus? □ Yes □ No *Please Provide Documentation.*

Does patient have a history of alcohol abuse, illegal drug use, or drug addiction within the 12 months prior to starting Voquezna(vonoprazan)? □ Yes □ No *Please Provide Documentation.*

Does patient regularly consume greater than 21 units of alcohol (1 unit = 12 oz/300 mL beer, 1.5 oz/25 mL hard liquor/spirits, or 5 oz/100 mL wine)? □ Yes □ No *Please Provide Documentation.*

Renewal for One-time Maintenance Request:

Has patient been treated for a minimum of 8 weeks with 20mg Voquezna(vonoprazan) daily, unless patient required a lower dose? □ Yes □ No *Please Provide Documentation.*

Does patient have endoscopic healing from erosive esophagitis? □ Yes □ No *Please provide confirmation with endoscopy report.*

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909