



PRIOR AUTHORIZATION REQUEST

Voquezna

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number:	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength:	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for ALL PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is this request for INITIAL or CONTINUATION of therapy? <input type="checkbox"/> Initial (If checked, go to 8) <input type="checkbox"/> Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication?	Yes	No

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	[If no, skip to question 8.]		
3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 8.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 8.]	Yes	No
5	What is the diagnosis or condition? <input type="checkbox"/> Helicobacter pylori (H. Pylori) (If checked, no further questions) <input type="checkbox"/> Erosive Esophagitis (EE) (If checked, go to 6) <input type="checkbox"/> Non-Erosive Gastroesophageal Reflux Disease (GERD) (If checked, no further questions) <input type="checkbox"/> Other (If checked, no further questions)		
6	Has the patient been treated for greater than 6 months? ACTION REQUIRED: Submit supporting documentation. [Note: Submit supporting documentation confirming treatment start date.] [If yes, no further questions.]	Yes	No
7	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
9	Has documentation been submitted to confirm the patient does not have any of	Yes	No

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	<p>the following: A) Creatinine levels greater than 2 mg/dL, B) Alanine aminotransferase (ALT) or aspartate aminotransferase (ALP) greater than 2x the upper limit of normal, C) Total bilirubin greater than 2x upper limit of normal, D) Child-Pugh class B or C, E) Estimated glomerular filtration rate (eGFR) less than 30 mL/minute? ACTION REQUIRED: Submit supporting documentation.</p> <p>[If no, no further questions.]</p>		
10	<p>Has documentation been submitted to confirm that the patient has not had clinically significant upper or lower gastrointestinal bleeding within 4 weeks of starting treatment? ACTION REQUIRED: Submit supporting documentation.</p> <p>[If no, no further questions.]</p>	Yes	No
11	<p>Has documentation been submitted to confirm the patient does not have Zollinger-Ellison syndrome or other gastric acid hypersecretory conditions? ACTION REQUIRED: Submit supporting documentation.</p> <p>[If no, no further questions.]</p>	Yes	No
12	<p>Is the patient a female of childbearing potential?</p> <p>[If no, skip to question 14.]</p>	Yes	No
13	<p>Does the provider attest the patient will use an adequate contraceptive from day 1 until 4 weeks after last dose of medication?</p> <p>[If no, no further questions.]</p>		
14	<p>Does the provider attest that the patient will not take the requested medication concomitantly with rilpivirine-containing products?</p> <p>[If no, no further questions.]</p>	Yes	No
15	<p>What is the diagnosis or condition?</p> <p><input type="checkbox"/> Helicobacter pylori (H. Pylori) (If checked, go to 16)</p> <p><input type="checkbox"/> Erosive Esophagitis (EE) (If checked, go to 21)</p> <p><input type="checkbox"/> Non-Erosive Gastroesophageal Reflux Disease (GERD) (If checked, go to 27)</p> <p><input type="checkbox"/> Other (If checked, no further questions)</p>		

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16	<p>Has the diagnosis of H. Pylori been confirmed by 13C-urea breath test (UBT) and follow-up upper endoscopy in the past 45 days? ACTION REQUIRED: Submit supporting documentation.</p> <p>[If no, no further questions.]</p>	Yes	No
17	<p>Has the patient had an inadequate response to TWO of the following preferred regimens for H. Pylori: A) Clarithromycin Triple Therapy: proton pump inhibitor (PPI) plus amoxicillin plus clarithromycin, B) Clarithromycin Quadruple Therapy: PPI plus amoxicillin plus clarithromycin plus metronidazole, C) Bismuth Quadruple Therapy: PPI plus bismuth subsalicylate plus metronidazole plus tetracycline, D) Non-Bismuth Quadruple Therapy: PPI plus amoxicillin plus metronidazole plus clarithromycin?</p> <p>[If yes, skip to question 19.]</p>	Yes	No
18	<p>Does the patient have a documented intolerance or contraindication with all preferred regimens for H. Pylori? ACTION REQUIRED: Submit supporting documentation.</p> <p>[If no, no further questions.]</p>	Yes	No
19	<p>Does the requested dose exceed FDA approved label dosing for the requested indication?</p> <p>[Note: Dosing is 20 mg plus amoxicillin 1,000 mg plus clarithromycin 500 mg, each given twice daily for 14 days OR 20 mg given twice daily plus amoxicillin 1,000 mg three times daily for 14 days.]</p> <p>[If yes, no further questions.]</p>	Yes	No
20	<p>Is the requested medication being prescribed by or in consultation with a gastroenterologist?</p> <p>[No further questions.]</p>	Yes	No
21	<p>Has the diagnosis of erosive esophagitis (EE) been confirmed by endoscopy? ACTION REQUIRED: Submit supporting documentation.</p> <p>[If no, no further questions.]</p>	Yes	No
22	<p>Has the patient been screened and found negative for H. Pylori in the last 60 days? ACTION REQUIRED: Submit supporting documentation.</p> <p>[If no, no further questions.]</p>	Yes	No
23	<p>Has the patient tried and failed at least THREE plan preferred proton pump</p>	Yes	No

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	inhibitors (PPIs) for at least 8 weeks each? [If yes, skip to question 25.]		
24	Does the patient have a documented intolerance or contraindication with all plan preferred PPIs? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
25	Does the requested dose exceed FDA approved label dosing for the requested indication? [Note: Dosing is 20 mg once daily for 8 weeks, then 10 mg once daily for up to 6 months.] [If yes, no further questions.]	Yes	No
26	Is the requested medication being prescribed by or in consultation with a gastroenterologist? [No further questions.]	Yes	No
27	Has the diagnosis of gastroesophageal reflux disease (GERD) been confirmed by patient symptoms (heartburn, regurgitation, chest pain), or endoscopy? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
28	Has the patient tried and failed TWO plan preferred proton pump inhibitors (PPIs) for at least three months each? [If yes, skip to question 30.]	Yes	No
29	Does the patient have a documented intolerance, contraindication to, or failed treatment with all plan preferred PPIs? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
30	Does the requested dose exceed FDA approved label dosing for the requested indication? [Note: Dosing is 10 mg once daily for 4 weeks.] [If yes, no further questions.]	Yes	No
31	Is the requested medication being prescribed by or in consultation with a gastroenterologist?	Yes	No

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Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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