Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Voquezna (vonoprazan) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- see below; Continuation- see below

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Voquezna (vonoprazan)** for **Commercial, Exchange, FEHB (Federal),** and **MD Medicaid** plans**.** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**
KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

Length of authorization:

Initial: 1 month (Treatment of *H. pylori*), **6 months** (Treatment of erosive esophagitis)
Continuation: 6 months (Treatment of erosive esophagitis ONLY)

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

If treating *Helicobacter pylori (H. pylori)* infection (1 month approval):

1. Is this medication being prescribed by a Gastroenterologist?
   □ No □ Yes

2. Is the patient ≥18 years old?
   □ No □ Yes

3. Has the patient had inadequate response, contraindication, or intolerance to at least TWO of the following preferred therapies for *H. pylori*? (Select all applicable regimens)
   - ☐ Clarithromycin-based quadruple therapy (i.e., amoxicillin + metronidazole + clarithromycin + pantoprazole) - *1st line*
   - ☐ Bismuth-based quadruple regimen (i.e. amoxicillin + clarithromycin + bismuth pantoprazole) - *1st line*
   - ☐ Bismuth-based quadruple regimen (i.e. metronidazole + doxycycline + bismuth + pantoprazole) - *1st line if patient has penicillin allergy*
   - ☐ Bismuth quadruple regimen (levofloxacin + bismuth + doxycycline + pantoprazole) - *2nd line*
   - ☐ Bismuth + metronidazole + doxycycline + pantoprazole OR bismuth + doxycycline + clarithromycin + pantoprazole) - *2nd line if suspected Levaquin resistance*
   - ☐ Rifabutin triple regimen (amoxicillin + rifabutin + pantoprazole) - *3rd line*
   - ☐ High dose dual regimen (amoxicillin 1gm + pantoprazole 40 mg BID) - *3rd line*
   - ☐ Levaquin quadruple (levofloxacin + bismuth + doxycycline or metronidazole + pantoprazole - *3rd line*

   □ No □ Yes

If treating erosive esophagitis (6 month approval):

1. Is this medication being prescribed by a Gastroenterologist?
   □ No □ Yes

2. Does the patient have a diagnosis of erosive esophagitis (EE)?
   □ No □ Yes

3. Is the patient 18 years of age or older?
   □ No □ Yes

4. Has the patient had inadequate response (after an 8-week trial), contraindication or intolerance to at least FOUR of the following generic or over-the-counter (OTC) PPIs? (Select all applicable PPIs)
   - ☐ Omeprazole (Prilosec)
   - ☐ Esomeprazole (Nexium)
   - ☐ Pantoprazole (Protonix)
   - ☐ Lansoprazole (Prevacid/Prevacid Solutab)
   - ☐ Rabeprazole (Aciphex), dexlansoprazole (Dexilant)

   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below (for EE indication ONLY):

1. Has the patient experienced positive clinical response?
   □ No □ Yes

2. Has specialist follow-up occurred within the last 12 months?
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**