

Prior Authorization Drug Attachment for Voquezna Tablets

Instructions

Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Voquezna Tablets Instructions, F-03384A. Prescribers may refer to the Forms page of the ForwardHealth Portal (the Portal) at forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization Drug Attachment for Voquezna Tablets form signed and dated by the prescriber before submitting a prior authorization (PA) request on the Portal, by fax, or by mail. Prescribers and pharmacy providers may call Provider Services at 800-947-9627 with questions.

Section I – Member information

1. Name – Member (Last, first, middle initial): _____

2. Member ID number: _____ 3. Date of birth – Member: _____

Section II – Prescription information

4. Drug name: _____ 5. Drug strength: _____

6. Date prescription written: _____ 7. Refills: _____

8. Directions for use: _____

9. Name – Prescriber: _____

10. Address – Prescriber (Street, city, state, ZIP+4 code):

11. Phone number – Prescriber: _____

12. National Provider Identifier – Prescriber: _____

Section III – Clinical information (Required for all PA requests)

Note: Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests.

13. Diagnosis code and description:



14. Indicate which medical condition Voquezna tablets are being prescribed for.

- ☐ Treatment of erosive esophagitis
- ☐ Maintenance of healed erosive esophagitis
- ☐ Treatment of non-erosive gastroesophageal reflux disease

15. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with **at least two** proton pump inhibitors?

- ☐ Yes ☐ No

a. Drug name: _____ Dates taken: _____

Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

b. Drug name: _____ Dates taken: _____

Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

c. Drug Name: _____ Dates Taken: _____

Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

Section IV – Authorized signature

16. Signature – Prescriber: _____

17. Date signed: _____

Section V – Additional information

18. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the requested drug may be included here.