**Department of Health Services State of Wisconsin**

Division of Medicaid Services Wis Admin. Code § DHS 107.10(2)

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# 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 [https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ ForwardHealthCommunications.aspx?panel=Forms](https://www.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 (20 mg only) (Approvals are up to 56 days.)

 [ ]  Maintenance of healed erosive esophagitis (10 mg only) (Approvals are up to 183 days.)

 [ ]  Treatment of non-erosive gastroesophageal reflux disease (10 mg only) (Approvals are up to 28 days.)

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

1. Drug Name:       Dates Taken:

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

2. Drug Name:       Dates Taken:

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

3. 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.