**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.