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 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.

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