TRICARE Prior Authorization Request Form for vonoprazan, amoxicillin (Voquezna Dual Pak); vonoprazan, amoxicillin, clarithromycin (Voquezna TripleP Pak)

JOHNS HOPKINS MEDICINE
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. **Multiple formulary medications to treat H. pylori are available for DOD beneficiaries without a prior authorization including lansoprazole, amoxicillin, and clarithromycin. Please consider changing the prescription to one of these formulary medications.**	☐ Acknowledged Proceed to question **2**	
2. **Is the patient GREATER THAN or EQUAL to 18 years of age?**	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. **Is the requested medication prescribed by or in consultation with a gastroenterologist or infectious disease specialist?**	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. **Has the patient tried and failed two 14-day trials with a guideline-recommended first-line treatment regimen?** Appropriate treatment combinations for H. pylori include: omeprazole, lansoprazole, amoxicillin, rifabutin, clarithromycin, bismuth subsalicylate, metronidazole, tetracycline, and PPI or H2 blockers). Note: Failure is defined as failure to eradicate H. pylori infection after a 14-day course of therapy.	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[09 November 2022]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#: