TRICARE Prior Authorization Request Form for
vonoprazan **(Voquezna)**

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

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.

Prior authorization does not expire.

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. Is the patient 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have a diagnosis of erosive esophagitis or Helicobacter pylori (H. pylori) infection?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the prescription written by a gastroenterologist or infectious disease specialist?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Prescriber acknowledges that omeprazole capsules and pantoprazole tablets are the Department of Defense's preferred Proton Pump Inhibitors and are available without a prior authorization.	☐ Acknowledged Proceed to question **5**	
5. Has the patient had an inadequate response or adverse reaction after a trial of ALL of the following: omeprazole capsules (Prilosec), pantoprazole tablets (Protonix), esomeprazole capsules (Nexium), and rabeprazole tablets (Aciphex)?	☐ Yes **Sign and date below**	☐ No Proceed to question **6**
6. Does the patient have a contraindication to ALL of the following: omeprazole (Prilosec), pantoprazole (Protonix), esomeprazole capsules (Nexium), and rabeprazole tablets (Aciphex)?	☐ 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 _____

[5 December 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: