Louisiana Medicaid
***H. pylori* Treatment**

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request:

- Clinical authorization for single-ingredient vonoprazan (Voquezna®) tablets; **OR**
- Prior authorization for non-preferred *H. pylori* treatment.

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Non-Preferred *H. pylori* Treatment Agents (except single-ingredient Voquezna® tablets)

Approval Criteria for Initiation and Continuation of Therapy

- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- If the request is for a non-preferred *H. pylori* combination product, there is a documented inability to use separate preferred products in the therapeutic classes represented by the individual active ingredients in the requested non-preferred *H. pylori* product (if indicated); **AND**
- Previous use of a preferred product - **ONE** of the following is required:
    - The recipient has had a *treatment failure* with at least one preferred product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
    - The recipient has *documented contraindication(s)* to the preferred products that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated.

Duration of approval for initiation and continuation of therapy: 2 weeks to 1 month
An appropriate duration of initial authorization and reauthorization approval (if needed) will be determined based upon patient-specific factors and the condition being treated.

Vonoprazan (Voquezna®) [single-ingredient tablets]

Approval Criteria

- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of:
    - ~~erosive~~ Erosive esophagitis confirmed by endoscopy within the previous 12-month period (Date of endoscopy must be **stated on the request**); **AND**
        - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a gastroenterologist; **AND**
        - The recipient failed treatment with an adequate trial (2 months each) of at least **TWO** proton pump inhibitors or has an intolerance or contraindication to **ALL** proton pump inhibitors indicated to treat erosive esophagitis; **OR**
    - Heartburn ~~,~~associated with non-erosive gastroesophageal reflux disease (GERD); **AND**

- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a gastroenterologist; **AND**
- The recipient has a history of onset of heartburn at least 6 months prior to the date of the request; **AND**
- The recipient failed treatment with an adequate trial (2 months each) of at least **TWO** proton pump inhibitors or has an intolerance or contraindication to ALL proton pump inhibitors; **AND**
- The recipient has not had Voquezna in the previous 6-month period.

Duration of authorization for erosive esophagitis: 8 months
Duration of authorization for heartburn associated with GERD: 4 weeks per 6 months period
Subsequent authorization of Voquezna® for both erosive esophagitis and for heartburn associated with GERD will require meeting the approval criteria, AND, for erosive esophagitis only, documented healing of the previous case of erosive esophagitis.

References

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; https://www.clinicalkey.com/pharmacology/

DiPiro JT, Talbert RL, Yee GC, Matzke GR, Wells BG, Posey L. eds. Pharmacotherapy: A Pathophysiologic Approach, 10e New York, NY: McGraw-Hill; https://accesspharmacy.mhmedical.com/book.aspx?bookid=1861

Vonoprazan (Voquezna) [package insert]. Buffalo Grove, IL: Phathom Pharmaceuticals, Inc; ~~November~~ July ~~2023~~2024. https://www.phathompharma.com/wp-content/uploads/VOQUEZNA-tablets-Prescriber-Information.pdf

Revision / Date	Implementation Date
Single PDL Implementation	May 2019
Added wording for H. Pylori combination products use of individual agents / June 2019	July 2019
Separated “Select Therapeutic Classes Not Established” into individual therapeutic class documents / November 2019	January 2020
Formatting changes / April 2021	July 2021
Added clinical criteria for single-ingredient Voquezna®, formatting changes / February 2024	July 2024
Added indication of non-erosive GERD for Voqezna®, updated references / August 2024	January 2025