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**
- ~~P~~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.
~~*These agents may have **Black Box Warnings** and/or may be subject to **Risk Evaluation and Mitigation Strategy (REMS)** under FDA safety regulations. Please refer to individual prescribing information for details.*~~

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

Approval Criteria for ~~Initial and Reauthorization Requests~~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.~~;~~ ~~**AND**~~
- ~~By submitting the authorization request, the prescriber attests to the following:~~
  - ~~The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**~~
  - ~~All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**~~
  - ~~The recipient has no concomitant drug therapies or disease states that limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling.~~

Duration of approval for ~~initial~~ initiation and ~~reauthorization~~continuation of therapy ~~approval~~: 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 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.

Duration of authorization: 8 months
Subsequent authorization of Voquezna® will require meeting the approval criteria AND 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 2023. 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