

Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	May 10, 2024

## **VOQUEZNA® (vonoprazan)**

**LENGTH OF AUTHORIZATION:** 14 days (H. Pylori) or 6 months (erosive esophagitis)

**REVIEW CRITERIA:**

- Patient must be  $\geq$  18 years of age; **AND**
- Prescribed by or in consultation with a gastroenterologist or infectious disease specialist

**Erosive Esophagitis**

- Patient has documented diagnosis of erosive esophagitis; **AND**
- Patient has had trial and failure to two preferred proton pump inhibitors (e.g. esomeprazole, omeprazole, pantoprazole)

**Helicobacter pylori (H. pylori) infection**

- Patient has documented diagnosis of Helicobacter pylori (H. pylori) infection; **AND**
- Patient has had a trial and failure, inadequate response, or intolerance to bismuth quadruple therapy (e.g., bismuth and metronidazole and tetracycline and proton pump inhibitor); **OR**
- If the patient has a contraindication or intolerance to bismuth quadruple therapy, patient has had a trial and failure, inadequate response, or intolerance to clarithromycin-based therapy (e.g., clarithromycin based triple therapy, clarithromycin based concomitant therapy).

**DOSING AND ADMINISTRATION:**

- Refer to product labeling at <https://www.accessdata.fda.gov/scripts/cder/daf/>
- Available as 10mg and 20mg tablets.