

Prescriber Criteria Form

Voquezna Pak 2026 PA Fax 5470-A v1 010126.docx

Voquezna Dual Pak (vonoprazan tablets/amoxicillin capsules), Voquezna Triple Pak (vonoprazan tablets/amoxicillin capsules/clarithromycin tablets)

Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Voqueznak.

Drug Name (select from list of drugs shown):

Patient Name:

Patient ID:

Patient DOB:

Patient Phone:

Prescriber Name:

Prescriber Address:

City:

State:

Zip:

Prescriber Phone:

Prescriber Fax:

Diagnosis:

ICD Code(s):

Please circle the appropriate answer for each question.

1	Is the requested drug being prescribed for the treatment of Helicobacter pylori (H. pylori) infection? [If no, then no further questions.]	Yes	No
2	Is the infection proven or strongly suspected to be caused by susceptible bacteria based on any of the following: A) culture and susceptibility, B) local epidemiology and susceptibility patterns?	Yes	No

Comments:

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ Date: _____