Pharmacy Drug Policy & Procedure

Policy Name:	Voquezna (vonoprazan products)	Policy#:	3181P

Purpose of the Policy

The purpose of this policy is to establish the criteria for coverage of Voquezna products including Voquezna (monotherapy), Voquezna dual pack (vonoprazan/amoxicillin) and Voquezna triple pack (vonoprazan/amoxicillin/clarithromycin).

Statement of the Policy

Health Alliance Medical Plans will approve the use of Voquezna products including Voquezna (monotherapy), Voquezna dual pack (vonoprazan/amoxicillin) or Voquezna triple pack (vonoprazan/amoxicillin/clarithromycin) under the pharmacy benefit if the following criteria are met.

Criteria

1. Coverage Criteria for *Helicobacter pylori* (*H. pylori*) Infection (dual/triple packs)

1.1 Diagnosis of *Helicobacter pylori* (*H. pylori*) infection
1.2 Age 18 years or older
1.3 Prescribed by or in consultation with a gastroenterologist (stomach doctor) or infection specialist
1.4 Documented trial and failure, intolerance or contraindication to a bismuth-based quadruple regimen (i.e. bismuth/tetracycline/metronidazole plus proton pump inhibitor (PPI) [e.g., omeprazole, lansoprazole])

2. Coverage Criteria for Gastroesophageal reflux disease (Voquezna monotherapy)

2.1 Diagnosis of gastroesophageal reflux disease with or without erosive esophagitis
2.2 Age 18 years or older
2.3 Prescribed by or in consultation with a gastroenterologist (stomach doctor)
2.4 Documented trial and failure, intolerance or contraindication to at least three acid suppressive therapies (e.g., omeprazole, famotidine, etc)

3. Exclusion Criteria

3.1 *H. pylori* strain resistant to amoxicillin or clarithromycin
3.2 Patient is taking any Rilpivirine containing products (Edurant)
3.3 Pregnancy (Voquezna triple pak)

4. Managed Dose Limit

4.1 Voquezna tablets: #30 tablets per 30 days
4.2 Voquezna Dual Pak and Triple Pak: 1 pack (#112) per 365 days

5. Approval Period

5.1 H. pylori: 1 pack per 12 months
5.2 GERD: 6 months

CPT Codes	
HCPCS Codes	

References

1. Voquezna (vonoprazan) [prescribing information]. Buffalo Grove, IL: Phathom Pharmaceuticals Inc; July 2024.
2. Chey WD, et al. Vonoprazan dual and triple therapy for Helicobacter pylori eradication. Am J Gastroenterol. 2021;116:S634.
3. Chey WD, Leontiadis GI, Howden CW, Moss SF. ACG clinical guideline: treatment of Helicobacter pylori infection. Am J Gastroenterol. 2017;112(2):212-239.
4. Chen JW, Vela MF, Peterson KA, et al. AGA Clinical Practice Update on the Diagnosis and Management of Extraesophageal Gastroesophageal Reflux Disease: Expert Review. Clin Gastroenterol Hepatol. 2023 Jun;21(6):1414-1421.e3.

Created Date: 04/05/2023
Effective Date: 04/05/2023
Posted to Website: 04/05/2023
Revision Date: 04/02/2025