BlueCross BlueShield
Federal Employee Program

VOQUEZNA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Voquezna (vonoprazan)

***Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Is this request for brand or generic? ❑Brand ❑Generic

2. Will the patient need more than 40 milligrams per day? ❑Yes***** ❑No
   If YES, please specify the requested milligrams per day: _____ mg per day

3. What is the patient's diagnosis?
   ❑Erosive esophagitis
   ❑Gastroesophageal reflux disease (GERD)
   a. Does the patient have non-erosive gastroesophageal reflux disease (GERD)? ❑Yes ❑No
   ❑H. pylori infection
   a. Will this medication be used in combination with amoxicillin OR amoxicillin and clarithromycin? ❑Yes ❑No
   ❑Other diagnosis ***(please specify):*** _____

4. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a proton pump inhibitor (PPI)? ❑Yes ❑No

5. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a histamine-2 (H2) receptor antagonist? ❑Yes ❑No