

Drug Policy

Policy:	Voquezna (vonoprazan)	Annual Review Date: 01/15/2026
		Last Revised Date: 01/15/2026

OVERVIEW

Voquezna is a potassium-competitive acid blocker indicated 1) for healing of all grades of erosive esophagitis and relief of heartburn associated with erosive esophagitis in adults; 2) to maintain healing of all grades of erosive esophagitis and relief of heartburn associated with erosive esophagitis in adults; 3) for the relief of heartburn associated with non-erosive gastroesophageal reflux disease in adults; 4) in combination with amoxicillin and clarithromycin for the treatment of *Helicobacter pylori* (*H. pylori*) infection in adults; 5) in combination with amoxicillin for the treatment of *H. pylori* infection in adults.

POLICY STATEMENT

This policy involves the use of Voquezna. Prior authorization is recommended for pharmacy benefit coverage of Voquezna. Approval is recommended for those who meet the conditions of coverage in the **Criteria and Initial/Extended Approval** for the diagnosis provided. **Conditions Not Recommended for Approval** are listed following the recommended authorization criteria. Requests for uses not listed in this policy will be reviewed for evidence of efficacy and for medical necessity on a case-by-case basis.

Because of the specialized skills required for evaluation and diagnosis of patients treated with Voquezna as well as the monitoring required for adverse events and long-term efficacy, initial approval requires Voquezna be prescribed by or in consultation with a physician who specializes in the condition being treated. All approvals for initial therapy are provided for the initial approval duration noted below; if reauthorization is allowed, a response to therapy is required for continuation of therapy unless otherwise noted below.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Voquezna is recommended in those who meet the following criteria:

1. Erosive Esophagitis

Criteria. Patient must meet the following criteria (A, B, and C):

- A. The patient is 18 year of age or older; AND
- B. The patient is seeking the requested medication for the relief of heartburn; AND
- C. The patient has tried a minimum of a 90-day trial of a generic proton pump inhibitor (PPI).

Note: Generic PPIs include dexlansoprazole, Esomeprazole, Lansoprazole, Omeprazole, Pantoprazole, Rabeprazole.

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Initial Approval/ Extended Approval.

- A) *Initial Approval:* 6 months
- B) *Extended Approval:* 6 months

2. Non-Erosive Gastroesophageal Reflux Disease

Criteria. Patient must meet the following criteria (A, B, and C):

- A. The patient is 18 year of age or older; AND
- B. The patient is seeking the requested medication for the relief of heartburn; AND
- C. The patient has tried a minimum of a 90-day trial of a generic proton pump inhibitor (PPI).
Note: Generic PPIs include dexlansoprazole, Esomeprazole, Lansoprazole, Omeprazole, Pantoprazole, Rabeprazole.

Initial Approval/ Extended Approval.

- A) *Initial Approval:* 30 days
- B) *Extended Approval:* 6 months

3. Helicobacter Pylori Infection

Criteria. Patient must meet the following criteria

- A. The patient is 18 year of age or older; AND
- B. The patient is using the requested medication in combination with amoxicillin; AND
- C. The patient has failed a trial with a generic proton pump inhibitor (PPI).
Note: Generic PPIs include dexlansoprazole, Esomeprazole, Lansoprazole, Omeprazole, Pantoprazole, Rabeprazole.

Initial Approval/ Extended Approval.

- A) *Initial Approval:* 30 days
- B) *Extended Approval:* Not recommended

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Voquezna has not been shown to be effective, or there are limited or preliminary data or potential safety concerns that are not supportive of general approval for the following conditions. (Note: This is not an exhaustive list of Conditions Not Recommended for Approval).

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

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Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational, or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

REFERENCES

1. Katz PO, Dunbar KB, Schnoll-Sussman FH, et al. ACG Clinical Guideline for the Diagnosis and Management of Gastroesophageal Reflux Disease. *Am J Gastroenterol*. 2022;117(1):27-56.
2. Voquezna® tablets [prescribing information]. Buffalo Grove, IL: Phathom; July 2024.