

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 3168-2
Program	Step Therapy – Voquezna® Paks
Medication	Voquezna Dual Pak® (vonoprazan and amoxicillin), Voquezna Triple® Pak (vonoprazan, amoxicillin and clarithromycin)
P&T Approval Date	11/2022, 7/2024
Effective Date	10/1/2024

1. Background:

Voquezna Dual Pak is a co-packaged product containing vonoprazan and amoxicillin. Voquezna Triple Pak is a co-packaged product containing vonoprazan, amoxicillin and clarithromycin. Voquezna Dual and Triple Pak are indicated for the treatment of *H. pylori* infection.

Step Therapy programs are utilized to encourage the use of lower cost alternatives for certain therapeutic classes. This program requires a member to try clarithromycin-based therapy or bismuth quadruple therapy prior to coverage for Voquezna.

2. Coverage Criteria^a:

A. Authorization

1. **Voquezna Dual Pak** and **Voquezna Triple Pak** will be approved based on **ONE** of the following criteria:

- a. History of failure, contraindication, or intolerance to **one** of the following clarithromycin-based therapies:
 - (1) clarithromycin-based triple therapy (i.e. clarithromycin, either amoxicillin or metronidazole, and a proton pump inhibitor)
 - (2) clarithromycin-based concomitant therapy (i.e. clarithromycin, amoxicillin, either tinidazole or metronidazole, and a proton pump inhibitor).

-OR-

- b. History of failure, contraindication, or intolerance to bismuth quadruple therapy (i.e. concomitant bismuth, metronidazole, tetracycline and a proton pump inhibitor).

Authorization will be issued for 1 month

^a State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Voquezna Dual Pak and Triple Pack [package insert].Buffalo Grove, IL: Phathom Pharmaceuticals Inc; May 2024.
2. Chey WD, Leontiadis GI, Howden CW, et al. ACG Clinical Guideline: Treatment of Helicobacter pylori infection. Am J Gastroenterol. 2017; 112:212-238
3. UptoDate. Treatment regimens for Helicobacter pylori in adults. May 2024. Accessed June 3, 2024.

Program	Step Therapy – Voquezna
Change Control	
Date	Change
11/2022	New program
7/2024	Annual review. Updated references.