GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
H. PYLORI TREATMENT PA SUMMARY

Preferred	Non-Preferred
Pylera (bismuth subcitrate/metronidazole/tetracycline)	Amoxicillin/clarithromycin/lansoprazole generic Omeclamox Pak (amoxicillin/clarithromycin/omeprazole) Talicia (omeprazole/amoxicillin/rifabutin) Voquezna (vonoprazan) Voquezna Dual Pak (vonoprazan/amoxicillin) Voquezna Triple Pak (vonoprazan/amoxicillin/clarithromycin)

LENGTH OF AUTHORIZATION: Varies

NOTES:

- Preferred and non-preferred agents require prior authorization.
- Omeprazole and pantoprazole are the preferred proton pump inhibitors.

PA CRITERIA:

Pylera

- For members with a diagnosis of *H pylori* infection when used in combination with a proton pump inhibitor, prescriber must submit a written letter of medical necessity stating the reasons the separate medications are not appropriate for the member.

.

Amoxicillin/Clarithromycin/Lansoprazole Generic and Omeclamox Pak

- For members with a diagnosis of *H pylori* infection, prescriber must submit a written letter of medical necessity stating the reasons the separate medications are not appropriate for the member.

Talicia

- For members 18 years or older with a diagnosis of *H pylori* infection who have failed therapy with, are resistant to or have allergies, contraindications, drug-drug interactions or intolerable side effects to at least 2 first-line antibiotics (i.e., clarithromycin, metronidazole, tetracycline), prescriber must submit a written letter of medical necessity stating the reasons the separate medications are not appropriate for the member.

Voquezna

- Approvable for members 18 years or older with a diagnosis of *H pylori* infection who have failed therapy with, are resistant to or have allergies, contraindications, drug-drug interactions or intolerable side effects to at least 2 first-line antibiotics (i.e., clarithromycin, metronidazole, tetracycline) and proton pump inhibitor (i.e., omeprazole, pantoprazole).

- Approvable for members 18 years or older with a diagnosis of erosive esophagitis or non-erosive gastroesophageal reflux disease (GERD) who have failed therapy with or have allergies, contraindications, drug-drug interactions or intolerable side effects to omeprazole and pantoprazole.

Voquezna Dual Pak and Triple Pak

- Approvable for members 18 years or older with a diagnosis of *H pylori* infection who have failed therapy with, are resistant to or have allergies, contraindications, drug-drug interactions or intolerable side effects to at least 2 first-line antibiotics (i.e., clarithromycin, metronidazole, tetracycline) and proton pump inhibitor (i.e., omeprazole, pantoprazole).

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827.**

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA AND APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.