Clinical Policy: Ulcer Therapy Products

Reference Number: CP.PMN.277
Effective Date: 06.01.22
Last Review Date: 05.26
Line of Business: Commercial, HIM/ICHRA, Medicaid Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The following are ulcer therapy products that require prior authorization:

- Bismuth subcitrate potassium/metronidazole/tetracycline hydrochloride (Pylera®)
- Omeprazole/clarithromycin/amoxicillin (Omeclamox-Pak®)
- Rifabutin/omeprazole/amoxicillin (Talicia®)
- Vonoprazan (Voquezna®)
- Vonoprazan/amoxicillin/clarithromycin (Voquezna™ Triple Pak™)
- Vonoprazan/amoxicillin (Voquezna™ Dual Pak™)

FDA Approved Indication(s)

- Pylera is indicated for use, in combination with omeprazole, for the treatment of patients with *Helicobacter pylori* infection and duodenal ulcer disease (active or history of within the past 5 years) to eradicate *H. pylori*.*
- Talicia, Voquezna (in combination with amoxicillin, or with amoxicillin and clarithromycin), Voquezna Triple Pak, and Voquezna Dual Pak are indicated for the treatment of *Helicobacter pylori* infection in adults.*
- Omeclamox-Pak is indicated for the treatment of patients with *Helicobacter pylori* infection and duodenal ulcer disease (active or up to one-year history) to eradicate *H. pylori*.*
- Voquezna is additionally indicated:
  - For healing of all grades of erosive esophagitis and relief of heartburn associated with erosive esophagitis in adults.
  - To maintain healing of all grades of erosive esophagitis and relief of heartburn associated with erosive esophagitis in adults.
  - For the relief of heartburn associated with non-erosive gastroesophageal reflux disease (GERD) in adults.

* *To reduce the development of drug-resistant bacteria and maintain the effectiveness of Pylera, Talicia, Omeclamox-Pak, Voquezna, Voquezna Triple/Dual Pak, and other antibacterial drugs, these products should be used only to treat or prevent infections that are proven or strongly suspected to be caused by bacteria.*

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Omeclamox-Pak, Pylera, Talicia, Voquezna, Voquezna Triple Pak, and Voquezna Dual Pak are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. *Helicobacter pylori* Infection (must meet all)**:**

1. Diagnosis of *H. pylori* infection;
2. Prescribed by or in consultation with a gastroenterologist or infectious disease specialist;
3. Age ≥ 18 years;
4. One of the following (a, b, c, or d):*
   **For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395*
   a. For Omeclamox-Pak requests, one of the following (i or ii):
      i. Member must instead use the individual components concurrently (amoxicillin, clarithromycin, omeprazole), unless contraindicated or clinically significant adverse effects are experienced;
      ii. Member must use generic Prevpac (lansoprazole, amoxicillin, clarithromycin), unless contraindicated or clinically significant adverse effects are experienced;
   b. For Pylera requests, both of the following (i and ii):
      i. Member must instead use the individual components concurrently (bismuth subcitrate, metronidazole, tetracycline), unless contraindicated or clinically significant adverse effects are experienced;
      ii. Prescribed in combination with a proton pump inhibitor (PPI; e.g., omeprazole);
   c. For Talicia requests, one of the following (i or ii):
      i. Member must instead use the individual components concurrently (omeprazole, amoxicillin, rifabutin), unless contraindicated or clinically significant adverse effects are experienced;
      ii. Member must use bismuth quadruple therapy, unless contraindicated or clinically adverse effects are experienced;
   d. For Voquezna and Voquezna Triple/Dual Pak requests, all of the following (i, ii and iii):
      i. Member must use bismuth quadruple therapy, unless contraindicated or clinically adverse effects are experienced;
      ii. For clarithromycin-containing regimens, *H. pylori* is clarithromycin-sensitive;
      iii. For Voquezna, prescribed in combination with one of the following (1 or 2):
         1) Amoxicillin;
         2) Amoxicillin and clarithromycin;
5. Dose does not exceed one of the following (a, b, c, d, e, or f):
   a. Omeclamox-Pak: two omeprazole capsules, two clarithromycin tablets, and four amoxicillin capsules per day for 10 days;
   b. Pylera: 12 capsules per day for 10 days;
   c. Talicia: 12 capsules per day for 14 days;
   d. Voquezna Triple Pak: two vonoprazan tablets, four amoxicillin capsules, and two clarithromycin tablets per day for 14 days;
   e. Voquezna Dual Pak: two vonoprazan tablets and six amoxicillin capsules per day for 14 days;

f. Voquezna (i and ii):
   i. 40 mg per day for 14 days, in combination with amoxicillin with or without clarithromycin;
   ii. 2 tablets per day for 14 days.

Approval duration:
Omeclamox-Pak, Pylera – 10 days
Talicia, Voquezna, Voquezna Triple/Dual Pak – 14 days

B. Erosive Esophagitis (must meet all)**:**
1. Request is for Voquezna;
2. Diagnosis of erosive esophagitis;
3. Age ≥ 18 years;
4. Failure of ≥ 8 week trial of a PPI at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;*
   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
5. Voquezna therapy does not exceed a total duration of 8 months;
6. Dose does not exceed the following (a and b):
   a. One of the following (i or ii):
      i. For the healing of erosive esophagitis: 20 mg per day for 8 weeks;
      ii. For the maintenance of erosive esophagitis: 10 mg per day for 6 months;
   b. 1 tablet per day.

Approval duration: Up to 8 months

C. Non-Erosive Gastroesophageal Reflux Disease (must meet all)**:**
1. Request is for Voquezna;
2. Diagnosis of non-erosive GERD with heartburn confirmed by both of the following tests (a and b):
   a. Endoscopy;
   b. Reflux monitoring;
3. Age ≥ 18 years;
4. Failure of two PPIs, each used for ≥ 4 weeks at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;*
   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
5. Dose does not exceed the following (a and b):
   a. 10 mg per day;
   b. 1 tablet per day.

Approval duration: 4 weeks

D. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of

business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. *Helicobacter pylori* Infection, Erosive Esophagitis

1. Re-authorization is not permitted. Members must meet the initial approval criteria.

Approval duration: Not applicable

B. Non-Erosive Gastroesophageal Reflux Disease (must meet all):

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Request is for Voquezna;
3. Member is responding positively to therapy;
4. Voquezna therapy does not exceed a total duration of 6 months;
5. If request is for a dose increase, new dose does not exceed both (a and b):
   a. 10 mg per day;
   b. 1 tablet per day.

Approval duration: up to 6 months

C. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND

criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, CP.PMN.53 for Medicaid, and HIM.PA.154 for health insurance marketplace/ICHRA, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
GERD: gastroesophageal reflux disease
PPI: proton pump inhibitor

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
bismuth quadruple regimen	***H. pylori* infection:** 10-14 days: PPI (standard dose) BID; bismuth subcitrate (120-300 mg) or subsalicylate (300 mg) QID; tetracycline 500 mg QID; metronidazole 250 mg QID or 500 mg TID-QID	See dosing regimen
PPIs: lansoprazole, omeprazole, pantoprazole, rabeprazole, esomeprazole	**Erosive Esophagitis and Non-Erosive GERD:** Varies	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Omeclamox-Pak: known hypersensitivity to omeprazole, any macrolide antibiotic, any penicillin, or any component of the formulations, coadministration with pimozide, lurasidone, ergotamine or dihydroergotamine
  - Pylera: disulfiram usage within the last two weeks, alcoholic beverage consumption for at least three days during or after therapy, patients with Cockayne syndrome, severe renal impairment, women who are pregnant, known hypersensitivity to product components

- Talicia: known hypersensitivity to the components of Talicia; patients receiving rilpivirine-containing products, delavirdine or voriconazole
- Voquezna: known hypersensitivity to vonoprazan or any component of Voquezna; rilpivirine-containing products
- Voquezna Triple Pak: known hypersensitivity to vonoprazan, amoxicillin or any other beta-lactams, clarithromycin or any other macrolide antimicrobial, or any component of Voquezna Triple Pak; rilpivirine-containing products; due to clarithromycin component: pimozide, lomitapide, lovastatin, simvastatin, ergot alkaloids (ergotamine or dihydroergotamine), colchicine in renal or hepatic impairment, history of cholestatic jaundice/hepatic dysfunction with use of clarithromycin, lurasidone
- Voquezna Dual Pak: known hypersensitivity to vonoprazan, amoxicillin or any other beta-lactams, or any component of Voquezna Dual Pak; rilpivirine-containing products

- Boxed warning(s):
  - Pylera: potential for carcinogenicity (metronidazole has been shown to be carcinogenic in mice and rats)

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Omeprazole/ clarithromycin/ amoxicillin (Omeclamox-Pak)	H. pylori	omeprazole 20 mg plus clarithromycin 500 mg plus amoxicillin 1,000 mg, each given PO BID for 10 days	See regimen
Bismuth subcitrate potassium/ metronidazole/ tetracycline hydrochloride (Pylera)	H. pylori	Three capsules PO QID for 10 days with omeprazole 20 mg BID	See regimen
Rifabutin/omeprazole/ amoxicillin (Talicia)	H. pylori	Four capsules PO TID (at least 4 hours apart) for 14 days	See regimen
Vonoprazan/ amoxicillin/ clarithromycin (Voquezna Triple Pak)	H. pylori	Each of the following given BID for 14 days: vonoprazan 20 mg (2 tablets/day), amoxicillin 1,000 mg (4 capsules/day), and clarithromycin 500 mg (2 tablets/day)	See regimen
Vonoprazan/ amoxicillin (Voquezna Dual Pak)	H. pylori	Vonoprazan 20 mg BID (2 tablets/day) and amoxicillin 1,000 mg TID a day (6 capsules/day) for 14 days	See regimen
Vonoprazan (Voquezna)	H. pylori	*Dual therapy*: 20 mg PO BID in combination with amoxicillin 1,000 mg PO TID for 14 days	20 mg/day for 14 days

Drug Name	Indication	Dosing Regimen	Maximum Dose
		Triple therapy: 20 mg PO BID in combination with amoxicillin 1,000 mg and clarithromycin 500 mg PO BID for 14 days	
	Erosive esophagitis	*Healing*: 20 mg PO QD for 8 weeks *Maintenance*: 10 mg PO QD for up to 6 months	See regimen
	Non-erosive GERD	10 mg PO QD for 4 weeks	10 mg/day

VI. Product Availability

Drug Name	Availability
Omeprazole/clarithromycin/ amoxicillin (Omeclamox-Pak)	Pack of 10 daily administration cards for morning and evening dosing, each containing: • Two 20 mg omeprazole delayed-release capsules • Two 500 mg clarithromycin tablets • Four 500 mg amoxicillin capsules
Bismuth subcitrate potassium/ metronidazole/tetracycline hydrochloride (Pylera)	Each capsule contains: 140 mg of bismuth subcitrate potassium, 125 mg metronidazole, 125 mg of tetracycline hydrochloride
Rifabutin/omeprazole/ amoxicillin (Talicia)	Delayed-release capsule: omeprazole 10 mg, (equivalent to 10.3 mg of omeprazole magnesium), amoxicillin 250 mg, and rifabutin 12.5 mg
Vonoprazan/amoxicillin/ clarithromycin (Voquezna Triple Pak)	Carton of 14 daily administration packs for morning and evening dosing, each containing the following three drug products: tablets: vonoprazan 20 mg, clarithromycin 500 mg; capsules: amoxicillin 500 mg
Vonoprazan/amoxicillin (Voquezna Dual Pak)	Carton of 14 daily administration packs for morning, mid-day, and evening dosing, each containing the following two drug products: tablets: vonoprazan 20 mg; capsules: amoxicillin 500 mg
Vonoprazan (Voquezna)	Tablets: 10 mg, 20 mg

VII. References

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12. Homan M, Jones NL, Bontems P, et al. Updated joint ESPGHAN/NASPHAN guidelines for management of *Helicobacter pylori* infection in children and adolescents (2023). J Pediatr Gastroenterol Nutr 2024;79:758-785.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created per February SDC and prior clinical guidance (Talicia removed from CP.PMN.223).	02.17.22	05.22
RT4: added Voquezna Triple/Dual Pak to criteria with specific redirection based on *H. pylori* clarithromycin- and amoxicillin-sensitivity.	06.08.22	08.22
Template changes applied to other diagnoses/indications.	10.07.22	
2Q 2023 annual review: no significant changes; added boxed warning for Pylera to Appendix C; simplified dosing regimen for Talicia in initial criteria and dosing table; references reviewed and updated	02.02.23	05.23
RT4: added Voquezna with corresponding criteria set for erosive esophagitis; updated Appendix C with Voquezna Triple/Dual Pak contraindications; renamed policy from Ulcer Therapy Combinations to Ulcer Therapy Products.	11.15.23	02.24

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2024 annual review: no significant changes; for Omeclamox-Pak updated contraindications to include coadministration with lurasidone per updated prescribing information; updated Talicia dosing in Section V; references reviewed and updated.	01.10.24	05.24
RT4: added criteria for Voquezna's new indication of non-erosive GERD.	08.27.24	11.24
2Q 2025 annual review: for H. pylori infection, removed required redirection to generic Prevpac for all agents except for Omeclamox-Pak; for Talicia, added redirection to bismuth quadruple therapy; for Voquezna and Voquezna Triple/Dual Pak if request is for a clarithromycin-containing regimens, added requirement that *H. pylori* is clarithromycin-sensitive; for Voquezna, added requirement that it is prescribed in combination with amoxicillin or amoxicillin and clarithromycin; references reviewed and updated.	01.21.25	05.25
Added step therapy bypass for IL HIM per IL HB 5395.	07.14.25	
2Q 2026 annual review: no significant changes; references reviewed and updated. Added ICHRA line of business.	03.26.26	05.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a

discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.