



Request for Prior Authorization
VERICIGUAT (VERQUVO)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for vericiguat (Verquvo). Payment will be considered under the following conditions:

- 1) Patient has a diagnosis of symptomatic chronic heart failure (NYHF Class II-IV) with a left ventricular ejection fraction (LVEF) ≤ 45%; and
2) Patient meets one of the following:
a. Recent hospitalization for heart failure (within the last 6 months); or
b. Recent need for outpatient intravenous diuretics (within the last 3 months); and
3) Patient is within the FDA labeled age for indication; and
4) Female patients of reproductive potential have been advised to use effective contraception during treatment and for at least one month after the last dose; and
5) Will not be used concomitantly with other soluble guanylate cyclase (sGC) stimulators (e.g. riociguat) or phosphodiesterase type 5 (PDE-5) inhibitors (e.g. sildenafil, tadalafil, vardenafil); and
6) Documentation of prior or current therapy, at a maximally tolerated dose, with one drug from each category below:
a. Renin-angiotensin system inhibitor (angiotensin converting enzyme [ACEI], angiotensin receptor blocker [ARB], or angiotensin receptor-neprilysin inhibitor [ARNI]); and
b. Evidence-based beta-blocker (carvedilol, metoprolol succinate, or bisoprolol); and
7) Is dosed based on FDA approved dosing; and
8) Initial requests for Verquvo 2.5mg and 5mg tablets will be limited to one 14-day supply for each strength.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred

Verquvo

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

Document LVEF:

**Request for Prior Authorization  
VERICIGUAT (VERQUVO)**

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**Patient meets one of the following:**

Recent hospitalization for heart failure: Provide date: \_\_\_\_\_

Recent need for outpatient intravenous diuretics: Provide date & drug name: \_\_\_\_\_

**Female patient of reproductive potential has been advised to use effective contraception during treatment and for at least one month after last dose?**  Yes  No

**Will Verquvo be used in combination with sGC stimulators or PDE-5 inhibitors?**  Yes  No

**Document prior or current therapy, at maximally tolerated dose, with one drug from each category below:**

**Renin-angiotensin system inhibitor (ACEI, ARB, ARNI):**

Name/Dose: \_\_\_\_\_ Trial Dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

**Evidence-based beta-blocker (carvedilol, metoprolol succinate, or bisoprolol):**

Name/Dose: \_\_\_\_\_ Trial Dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

Medical or contraindication reason to override trial requirements: \_\_\_\_\_

***Attach lab results and other documentation as necessary.***

Prescriber signature (Must match prescriber listed above.)	Date of submission
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**IMPORTANT NOTE:** *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*