iowa total care ia health link Hawki

Request for Prior Authorization
VERICIGUAT (VERQUVO)
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for vericiguat (Verquvo). Payment will be considered when patient has an FDA approved or compendia indicated indication for the requested drug under the following conditions:

1) **Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and**
2) **Patient has a diagnosis of symptomatic chronic heart failure (NYHF Class II-IV) with a left ventricular ejection fraction (LVEF) ≤ 45%; and**
3) **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**
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**
   c. **Mineralcorticoid receptor antagonist (MRA); and**
   d. **Sodium-glucose cotransporter 2 inhibitor (SGLT2i) indicated for the treatment of heart failure (empagliflozin or dapagliflozin); and**
7) **Initial requests for vericiguat (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:_____

iowa total care ia health link Hawki

Request for Prior Authorization
VERICIGUAT (VERQUVO)
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Document LVEF: _____

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:_____

Mineralocorticoid receptor antagonist (MRA):

Name/Dose:_____ Trial Dates: _____
Failure reason:_____

Sodium-glucose cotransporter 2 inhibitor (SGLT2i) indicated for the treatment of heart failure (empagliflozin or dapagliflozin):

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

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.*