UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Verquvo (vericiguat)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	

Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval (ALL of the following criteria must be met):

- ❑ Diagnosed with symptomatic chronic heart failure with an ejection fraction 45% or less and either:
  - Hospitalized due to heart failure within last 6 months. **OR**
  - Required IV diuretics as an outpatient within the previous 3 months.
- ❑ 18 years of age or older.
- ❑ Not pregnant.
- ❑ Not taking other soluble guanylate cyclase stimulators (e.g. riociguat).
- ❑ Concurrently receiving one or more guideline-directed medications for heart failure with reduced ejection fraction (unless not tolerated or contraindicated). Examples include:
  - Beta-blockers (carvedilol, metoprolol succinate, or bisoprolol).
    Medication and dose: ______________________
  - Angiotensin antagonist (ARNI, ACEI, ARB).
    Medication and dose: ______________________
  - Mineralocorticoid receptor antagonist (e.g. spironolactone) if LVEF < 35% or LVEF ≤ 40% with diabetes mellitus or post myocardial infarction with HF symptoms.
    Medication and dose: ______________________
  - Sodium-glucose cotransporter 2 (SGLT2 inhibitor) e.g. dapagliflozin or empagliflozin.
    Medication and dose: ______________________

Re-authorization Criteria:
Updated letter with medical justification or updated chart notes demonstrating positive clinical response.

Initial Authorization: Up to six (6) months
Re-authorization: Up to one (1) year

PROVIDER CERTIFICATION
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_______________________________ ____________

Prescriber's Signature Date