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:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per Dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
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):

- ☐ The patient is 18 years of age or older.
- ☐ The patient has a diagnosis of symptomatic chronic heart failure with an ejection fraction 45% or less and either:
  - ☐ Hospitalized due to heart failure within the last 6 months **OR**
  - ☐ Required IV diuretics as an outpatient within the previous 3 months.
- ☐ The patient is not pregnant.
- ☐ The patient is not taking other soluble guanylate cyclase stimulators (e.g. riociguat)
- ☐ The patient is 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: _____

Reauthorization Criteria:

- ☐ Updated letter with medical justification or updated chart notes demonstrating positive clinical response.

Initial Authorization: Up to six (6) months
Reauthorization: Up to one (1) year

Note:

- **Warning for embryo-fetal toxicity. To prevent pregnancy, females of reproductive potential must use effective forms of contraception during treatment and for one month after stopping treatment.**

PROVIDER CERTIFICATION

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

_____ _____

Prescriber's Signature Date