PRIOR AUTHORIZATION CRITERIA

BRAND NAME*
(generic)

VERQUVO
(vericiguat)

Status: CVS Caremark® Criteria
Type: Initial Prior Authorization ***Ref # 4446-A***

**Drugs that are listed in the target drug box include both brand and generic and all dosage forms and strengths unless otherwise stated. OTC products are not included unless otherwise stated.*

FDA-APPROVED INDICATIONS

Verquvo is indicated to reduce the risk of cardiovascular death and heart failure (HF) hospitalization following a hospitalization for heart failure or need for outpatient IV diuretics, in adults with symptomatic chronic HF and ejection fraction less than 45%.

COVERAGE CRITERIA

Chronic Heart Failure
Authorization may be granted when the requested drug is being prescribed to reduce the risk of cardiovascular death and heart failure hospitalization in an adult patient with symptomatic chronic heart failure when ALL of the following criteria are met:

- The patient has a left ventricular ejection fraction (LVEF) less than 45 percent. [ACTION REQUIRED: Documentation is required for approval.]
- The patient is currently receiving optimal therapy for heart failure management (e.g., angiotensin-converting enzyme inhibitor [ACEI], angiotensin II receptor blocker [ARB], angiotensin receptor-neprilysin inhibitor [ARNI], beta-blocker, sodium-glucose co-transporter-2 inhibitor [SGLT2I], mineralocorticoid receptor antagonist [MRA])
- The patient has had ANY of the following:
  - The patient has had hospitalization for heart failure within the past 6 months
  - The patient has had use of outpatient intravenous (IV) diuretics for heart failure within the past 3 months

CONTINUATION OF THERAPY

Chronic Heart Failure
Authorization may be granted when the requested drug is being prescribed to reduce the risk of cardiovascular death and heart failure hospitalization in an adult patient with symptomatic chronic heart failure when ALL of the following criteria are met:

- The patient has a left ventricular ejection fraction (LVEF) less than 45 percent. [ACTION REQUIRED: Documentation is required for approval.]
- The patient is currently receiving optimal therapy for heart failure management (e.g., angiotensin-converting enzyme inhibitor [ACEI], angiotensin II receptor blocker [ARB], angiotensin receptor-neprilysin inhibitor [ARNI], beta-blocker, sodium-glucose co-transporter-2 inhibitor [SGLT2I], mineralocorticoid receptor antagonist [MRA])

DURATION OF APPROVAL (DOA):

- 4446-A: DOA: 12 months

REFERENCES

1. Verquvo [package insert]. Rahway, NJ: Merck Sharp & Dohme Corp.; July 2023.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2024. https://online.lexi.com. Accessed April 12, 2024.
3. Micromedex (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/ (cited: 04/12/2024).
4. Heidenreich PA, Bozkurt B, Aguilar D et. al. 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *J Am Coll Cardiol.* 2022; 79:e263-e421.

Written by:	UM Development (CJH)
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Reviewed:	Medical Affairs (CHART) 02/11/2021, 03/25/2021, 03/31/2022, 07/28/2022, 04/27/2023, 04/25/2024 External Review: 02/2021, 06/2021, 06/2022, 10/2022, 08/2023, 09/2024

CRITERIA FOR APPROVAL

1	Is the requested drug being prescribed to reduce the risk of cardiovascular death and heart failure hospitalization in an adult patient with symptomatic chronic heart failure? [If Yes, then go to 2. If No, then no further questions.]	Yes	No
2	Does the patient have a left ventricular ejection fraction (LVEF) less than 45 percent? ACTION REQUIRED: If yes, then documentation is required for approval. Document the patient's left ventricular ejection fraction percentage: _____ [If Yes, then go to 3. If No, then no further questions.]	Yes	No
3	Has documentation of the patient's left ventricular ejection fraction percentage been submitted to CVS Health? [If Yes, then go to 4. If No, then no further questions.] Tech Note: Documentation of the patient's left ventricular ejection fraction percentage is required for approval.	Yes	No
4	Is the patient currently receiving optimal therapy for heart failure management (e.g., angiotensin-converting enzyme inhibitor [ACEI], angiotensin II receptor blocker [ARB], angiotensin receptor-neprilysin inhibitor [ARNI], beta-blocker, sodium-glucose co-transporter-2 inhibitor [SGLT2I], mineralocorticoid receptor antagonist [MRA])? [If Yes, then go to 5. If No, then no further questions.]	Yes	No
5	Is this request for continuation of therapy? [If Yes, then no further questions. If No, then go to 6.]	Yes	No
6	Has the patient had any of the following: A) Hospitalization for heart failure within the past 6 months, B) Use of outpatient intravenous (IV) diuretics for heart failure within the past 3 months? [No further questions]	Yes	No

Mapping Instructions			
	Yes	**No**	**DENIAL REASONS**
1.	Go to 2	Deny	Your plan only covers this drug when it is used for certain health conditions. Covered use is for risk reduction in symptomatic chronic heart failure. Your plan does not cover this drug for your health condition that your doctor told us you have. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Diagnosis]
2.	Go to 3	Deny	Your plan only covers this drug when your left ventricular ejection fraction (LVEF) is sent to us, and your test results are in a certain range (LVEF less than 45 percent). We denied your request because: A) We did not receive your results, or B) Your results were not in the approvable range. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Lab/test: LVEF]
3.	Go to 4	Deny	Your plan only covers this drug when your left ventricular ejection fraction (LVEF) is sent to us, and your test results are in a certain range (LVEF less than 45 percent). We denied your request because: A) We did not receive your results, or B) Your results were not in the approvable range. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Lab/test: LVEF]
4.	Go to 5	Deny	Your plan only covers this drug if you will be taking it with other drugs. We have denied your request because: A) You are not (or will not be) taking optimal therapy for heart failure management, and B) You do not have a medical reason not to take them. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Not on required concurrent therapy: optimal therapy]

5.	Approve, 12 Months	Go to 6	
6.	Approve, 12 Months	Deny	Your plan only covers this drug when A) You have had a hospitalization for heart failure within the last 6 months, or B) You have used intravenous (IV) diuretics for heart failure within the past 3 months. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Hospitalization or IV diuretics]