PA Request Criteria

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**CAREFIRST ASO**
**Verquvo**

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Verquvo.

**Patient Name:** _____ **Date:** 11/27/2023
**Patient ID:** _____ **Patient Date Of Birth:** _____
**Patient Group No:** _____ **Patient Phone:** _____ **Physician Name:**
**NPI#:** **Specialty:**
**Physician Office Address:** _____ **Physician Office Telephone:**

**Drug Name (select from list of drugs shown)**
Verquvo (vericiguat)

**Quantity:** _____ **Frequency:** _____ **Strength:** _____
**Route of Administration:** _____ **Expected Length of Therapy:** _____
**Diagnosis:** _____ **ICD Code:** _____

**Comments:** _____
_____
_____

**Please check the appropriate answer for each applicable question.**

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? **Y** ☐ **N** ☐
2. Does the patient have a left ventricular ejection fraction (LVEF) less than 45 percent? [If yes, then documentation is required for approval.] Left ventricular ejection fraction percentage: _____ **Y** ☐ **N** ☐
3. 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])? **Y** ☐ **N** ☐
4. Is this request for continuation of therapy? **Y** ☐ **N** ☐
5. 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? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

**Prescriber (Or Authorized) Signature and Date**