BlueCross BlueShield Federal Employee Program

VERQUVO
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Verquvo (vericiguat)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

How many tablets will the patient need for a 100 day supply? _____ tablet(s) per 100 days

1. Is the patient being treated with Verquvo for chronic heart failure? ❑Yes ❑No*****
   If NO, specify diagnosis: _____
2. Is the patient currently receiving optimal therapy for heart failure management (e.g., beta blocker, angiotensin-converting enzyme (ACE) inhibitor, angiotensin II receptor blocker (ARB), angiotensin receptor and neprilysin inhibitor (ARNI))? ❑Yes ❑No
3. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes***** ❑No
   If YES, will the patient be advised to use effective contraception during treatment with Verquvo and for one month after the last dose? ❑Yes ❑No
4. Will Verquvo be used in combination with other heart failure therapies such as a beta blocker, angiotensin-converting enzyme (ACE) inhibitor, angiotensin II receptor blocker (ARB), angiotensin receptor and neprilysin inhibitor (ARNI), or diuretics as tolerated? ❑Yes ❑No
5. Will Verquvo be used in combination with other soluble guanylate cyclase (sGC) stimulators, such as Adempas (riociguat)? ❑Yes***** ❑No
   If YES, specify medication: _____
6. Has the patient been on Verquvo continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. What level of activity causes the patient to experience shortness of breath or fatigue? ***Please select activity below:***
- ❑No symptoms and no limitations in ordinary activity (Class I)
- ❑Mild symptoms and slight limitations during ordinary activity (Class II)
- ❑Marked limitation in activity due to symptoms, even during less than ordinary activity (Class III)
- ❑Experience shortness of breath and fatigue while at rest (Class IV)

b. Does the patient have systolic dysfunction with a left ventricular ejection fraction less than 45%? ❑Yes ❑No

c. What is the prescriber's specialty? ❑Cardiologist ❑Other specialty ***(please specify)***: _____

If Other Specialty, did a cardiologist recommend treatment with Verquvo for this patient? ❑Yes ❑No

d. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a sodium-glucose cotransporter-2 (SGLT2) inhibitor? ❑Yes ❑No

e. Has the patient had a hospitalization for heart failure within the last six months? ❑Yes ❑No*****
   If NO, has the patient had outpatient IV diuretics for heart failure within the last three months? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

a. Has the patient's symptoms improved or stabilized with therapy? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***