Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
P.O. Box 5119, Helena, MT 59604
Phone 406.443.6002 . Toll-Free 1.800.395.7961
Fax 406.513.1928 . Toll-Free 1.800.294.1350

Montana Healthcare Programs Prior Authorization Request Form for Use of Verquvo (vericiguat)

Member Name:	DOB:	Date:
Medicaid ID:	Prescriber Phone:	
Prescriber Name/Specialty:	Prescriber Fax:	
Requested Dose/Directions:		

Please complete below information for applicable situation, **Initiation** or **Continuation** of therapy:

☐ **INITIATION OF THERAPY:** Member must meet all of the following criteria:

1. Member is 18 years of age or older: ☐ Yes ☐ No
2. Is member pregnant or nursing? ☐ Yes ☐ No

   If YES, therapy will not be approved.
3. Medication is being prescribed by, or in consult with, a cardiologist: ☐ Yes ☐ No

   Action Required: If not in a specialty clinic or written by a specialist, copy of annual specialty consult with an appropriate specialist is required (please attach copy of consult):

   Name of Specialist: _____ Contact Date: _____
4. Is member taking any soluble guanylate cyclase stimulators (e.g., riociguat): ☐ Yes ☐ No
5. Is member taking any phosphodiesterase type 5 inhibitors (e.g., sildenafil, tadalifl, vardenfil): ☐ Yes ☐ No

   If answered YES to #4 and/or #5, therapy will not be approved.
6. Member has diagnosis of chronic heart failure with an ejection fraction of 45% or less and is NYHA class II-IV: ☐ Yes ☐ No
7. Member meets either of the following:

   ☐ Has been hospitalized due to heart failure within the last 6 months, OR

   ☐ Required IV diuretics as an outpatient within the previous 3 months
8. Member is concurrently receiving the maximum tolerated or target dose of guideline-directed medical therapy for heart failure, unless not tolerated or contraindicated:

   ☐ Beta-blockers: Name:_____ Dates of use:_____

   ☐ Angiotensin antagonist: Name:_____ Dates of use:_____

☐ Mineralocorticoid receptor antagonist if LVEF < 35% or LVEF ≤ 40% with diabetes mellitus or post myocardial infarction with HF symptoms:
Name:_____ Dates of use:_____

LIMITATIONS: Maximumim daily dose is 10mg per day

Initial authorization will be granted for 6 months.

☐ **CONTINUATION OF THERAPY:**

1. Member has been adherent to therapy: ☐ Yes ☐ No (will be verified through claims history)
2. Provider must provide documentation showing positive clinical improvement.
3. Annual specialist consult attached if prescriber is not a specialist. ☐ Yes ☐ No ☐ N/A - prescriber is specialist

Reauthorization will be issued for 1 year.

Please complete form, including required attachments, and fax to:
Drug Prior Authorization Unit at 1-800-294-1350

7/2021