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

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>DOB:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid ID:</td>
<td>Prescriber Phone:</td>
<td></td>
</tr>
<tr>
<td>Prescriber Name/Specialty:</td>
<td>Prescriber Fax:</td>
<td></td>
</tr>
<tr>
<td>Requested Dose/Directions:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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, tadalafil, 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: Maximum 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