SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Verquvo® (vericiguat)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Quantity Limit: 30 tablets per 30 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Prescribed by or in consultation with a cardiologist

AND

- ❑ Member must be 18 years or age or older

AND

(Continued on next page)

- ❑ Member must have Chronic Heart Failure (CHF) classified by NYHA functional classed II-IV and be stabilized on standard of care defined as combination use of one of the following along **WITH** Entresto **(verified by chart notes or pharmacy paid claims)**:
  - ❑ ACE Inhibitor/ARB
  - ❑ Beta-Blocker
  - ❑ Spironolactone

AND

- ❑ Member must have an ejection fraction (EF) of < 45% assessed within the past 12 months

AND

- ❑ Member's systolic blood pressure must be > 100 mmHg

AND

- ❑ Member has had a previous heart failure hospitalization within the past 6 months or has required outpatient IV diuretic therapy for heart failure within the past 3 months **(documentation must be submitted with request)**

AND

- ❑ Member is not pregnant

AND

- ❑ Member will not use Adempas in combination with the requested medication

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee:** 3/12/2021
REVISED/REFORMATTED/UPDATED: ~~6/30/2021;~~ **10/27/2032**