# SENTARA COMMUNITY PLAN
# (MEDICAID)

## 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:** _____

**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.

**Initial Approval: 1 (ONE) year**

1. Is the member 18 years of age or older? **AND** ❑ Yes ❑ No
2. Does the member have a diagnosis of heart failure? **AND** ❑ Yes ❑ No
3. Does the member have an ejection fraction < 45%? **AND** ❑ Yes ❑ No
4. Does the member meet ≥ 1 of the following criteria?
   - Member has required the use of intravenous diuretics as an outpatient in the past 3 months; **OR**
   - Member was recently (i.e., within the last 6 months) hospitalized for heart failure; **AND**

   ❑ Yes ❑ No

**(Continued on next page)**

5. Is the member on guideline-directed therapy for heart failure, unless contraindicated (e.g., beta-blocker, angiotensin-converting enzyme [ACE] inhibitor or angiotensin II receptor blockers [ARB], and mineralocorticoid receptor antagonists/aldosterone antagonists)? **AND** ❑ Yes ❑ No
6. Is there confirmation that the member is **NOT** taking another soluble guanylate cyclase (sGC) stimulator or phosphodiesterase-5 (PDE-5) inhibitor? **AND** ❑ Yes ❑ No
7. If the member is of childbearing potential, is there confirmation that the member is **NOT** pregnant A**ND** is using contraception? ❑ Yes ❑ No

## Renewal Approval – 1 (ONE) year

1. Does the member continue to meet criteria questions 5 through 7 from above? **AND** ❑ Yes ❑ No
2. Is there prescriber attestation that the member is responding positively to treatment (e.g., symptom improvement, slowing of decline)? **AND** ❑ Yes ❑ No
3. Is there confirmation that the member has **NOT** experienced treatment-limiting adverse effects (e.g., symptomatic hypotension)? ❑ Yes ❑ No

***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.**



***REVISED/UPDATED/REFORMATTED:** ~~8/11/2021;~~ **11/10/2023**