Prior Authorization Form

CAREFIRST

Verquvo

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Verquvo.

Drug Name (select from list of drugs shown)
Verquvo (vericiguat)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the requested drug being prescribed to reduce the risk of cardiovascular death and heart failure hospitalization in an adult patient with symptomatic chronic heart failure? Y N

[If no, then no further questions.]

2. Does the patient have a left ventricular ejection fraction (LVEF) less than 45 percent? [If yes, then documentation is required for approval.] Left ventricular ejection fraction percentage. Y N _____

[If no, then no further questions.]

3. Is the patient currently receiving optimal therapy for heart Y N

	failure management (e.g., angiotensin-converting enzyme inhibitor [ACEI], angiotensin II receptor blocker [ARB], angiotensin receptor-neprilysin inhibitor [ARNI], beta-blocker, sodium-glucose co-transporter-2 inhibitor [SGLT2I], mineralocorticoid receptor antagonist [MRA])?	
	[If no, then no further questions.]	
4.	Is this request for continuation of therapy?	Y N
	[If yes, then no further questions.]	
5.	Has the patient had any of the following: A) Hospitalization for heart failure within the past 6 months, B) Use of outpatient intravenous (IV) diuretics for heart failure within the past 3 months?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date