Prescriber Criteria Form

Verquvo 2025 PA Fax 4436-A v1 010125.docx
Verquvo (vericiguat)
Coverage Determination

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 **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Verquvo (vericiguat).

Drug Name:
Verquvo (vericiguat)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

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 a patient with symptomatic chronic heart failure? [If no, then no further questions.]	Yes ◯	No ◯
2	Does the patient have a left ventricular ejection fraction (LVEF) less than 45 percent? [If no, then no further questions.]	Yes ◯	No ◯
3	Is this request for continuation of therapy? [If yes, then no further questions.]	Yes ◯	No ◯
4	Does the patient meet 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?	Yes ◯	No ◯

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____