



New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Verquvo®

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH:

 - -

GENDER:

 Male Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER:

 - -

FAX NUMBER:

 - -

SECTION III: CLINICAL HISTORY

1. Does the patient have a diagnosis of heart failure with ejection fraction < 45%? Yes No

2. Has the patient required use of intravenous (IV) diuretics in the past 3 months? Yes No

3. Has the patient been hospitalized for heart failure in the past 6 months? Yes No

4. Is the patient on guideline-directed therapy for heart failure? Yes No

List current therapy or note contraindication:

Beta-Blocker: _____

ACEi/ARB: _____

Mineralocorticoid receptor antagonist/aldosterone antagonist: _____

5. Is the patient receiving a soluble guanylate cyclase (sGC) stimulator (i.e., riociguat) or a PDE-5 inhibitor (i.e., sildenafil)? Yes No

6. If the patient is of childbearing potential, is the patient using contraception and has pregnancy been ruled out? Yes No



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PATIENT FIRST NAME:

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SECTION IV: FOR RENEWALS ONLY

1. Has the patient demonstrated efficacy (e.g., symptom improvement, slowing of decline)? Yes No

2. Has the patient experienced any treatment-limiting adverse effects (e.g., symptomatic hypotension)? Yes No

Provide any additional information that would help in the decision-making process. **If additional space is needed, please use another page.**

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ DATE: _____