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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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**: _____

Phone: 1-866-675-7755
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Magellan Rx MANAGEMENT