

New Hampshire Medicaid Fee-for-Service Program Verquvo[®] (vericiguat) Criteria

Approval Date: January 22, 2024

Medication

Brand Name	Generic Name	Dosage Strengths	Mechanism of Action	Indication
Verquvo®	vericiguat	2.5 mg, 5 mg, 10 mg tablets	mg, 5 mg, soluble Reduce the risk of cardiovascular (CV) de	

Criteria for Approval

- 1. Patient is ≥ 18 years of age; **AND**
- 2. Patient has a diagnosis of heart failure; AND
- 3. Patient's ejection fraction is < 45%; **AND**
- 4. Patient meets ≥ 1 of the following criteria:
 - a. Patient has required the use of intravenous diuretics as an outpatient in the past 3 months; **OR**
 - b. Patient was recently hospitalized for heart failure (within the last 6 months); AND
- 5. Patient is on a guideline-directed therapy for heart failure, unless contraindicated (e.g., betablocker, angiotensin-converting enzyme [ACE] inhibitor or angiotensin II receptor blockers [ARB], and mineralocorticoid receptor antagonists/aldosterone antagonists); **AND**
- 6. Patient is **not** taking another soluble guanylate cyclase (sGC) stimulator or phosphodiesterase-5 (PDE-5) inhibitor; **AND**
- 7. If patient is of childbearing potential, patient is **not** pregnant **and** is using contraception.

Criteria for Denial

1. Prior approval will be denied if the approval criteria are not met.

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Criteria for Renewal

- 1. Patient continues to meet above criteria; AND
- 2. Prescriber attestation that patient is responding positively to treatment (e.g., symptom improvement, slowing of decline); **AND**
- 3. Patient has not experienced treatment-limiting adverse effects (e.g., symptomatic hypotension).

Length of Authorization: 12 months

References

Available upon request.

Revision History

Reviewed by	Reason for Review	Date Approved
DUR Board	New	06/02/2022
Commissioner Designee	Approval	07/12/2022
DUR Board	Review	12/08/2023
Commissioner Designee	Approval	01/22/2024

