Clinical Policy Title:	vericiguat
Policy Number:	RxA.854
Drug(s) Applied:	Verquvo®
Original Policy Date:	10/11/2024
Last Review Date:	12/05/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Heart failure (must meet all)**:**

1. Diagnosis of symptomatic chronic heart failure.
2. Patient's left ventricular ejection fraction is less than 45%.

Approval duration

All Lines of Business (except Medicare): 12 months

II. Continued Therapy Approval

A. Heart failure (must meet all)**:**

1. Member is currently receiving medication that has been authorized by RxAdvance or the member has met initial approval criteria.

Approval duration

All Lines of Business (except Medicare): 12 months

References

1. Verquo Prescribing Information. Rahway, NJ: Merck Sharp & Dohme LLC; July 2023. Available at: https://www.merck.com/product/usa/pi_circulars/v/verquvo/verquvo_pi.pdf. Accessed October 11,2024.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	10/11/2024	12/05/2024

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

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