



Cardiovascular Agents – Vasoactive Soluble Guanylate Cyclase Stimulators

Please fax this completed form to (833) 645-2734 OR mail to: Centene Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at [CoverMyMeds.com](https://www.covermymeds.com).

Coordinated Care of Washington, Inc. (Apple Health) Preferred Drug list:

https://www.coordinatedcarehealth.com/content/dam/centene/centene-pharmacy/pdl/FORMULARY-CoordinatedCare_Washington.pdf

For policy criteria, see: https://www.coordinatedcarehealth.com/content/coordinatedcare/en_us/providers/resources/clinical-payment-policies.html/

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength		Directions for use	Qty/Days supply

1. Is this request for a continuation of therapy? Yes No
 If yes, does patient have clinical documentation demonstrating disease stability or a positive clinical response since starting vericiguat? Yes No

2. Is this prescribed by, or in consultation with, a cardiologist? Yes No

3. Indicate patient's diagnosis:
 Chronic heart failure with reduced ejection fraction
 Other. Specify: _____

4. Does patient have an ejection fraction less than 45%? Yes No

5. Does patient have a New York Heart Association (NYHA) Classification II-IV? Yes No

6. Has patient been prescribed vericiguat after any of the following? Check all that apply:
 A hospitalization due to heart failure
 Outpatient use of intravenous diuretics

7. Is patient being managed with any of the following at optimized doses unless contraindicated or not tolerated? Check all that apply:
 Beta-blocker
 Inhibitor of the renin-angiotensin system (e.g. angiotensin receptor-neprilysin inhibitor, angiotensin-converting enzyme inhibitor, angiotensin receptor blocker)
 Mineralocorticoid receptor antagonist

CHART NOTES ARE REQUIRED WITH THIS REQUEST		
Prescriber signature	Prescriber specialty	Date

Centene Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)