Effective Date: 01/01/2022
Current Effective Date: 9/1/2023
Last P&T Approval/Version: 10/2022
Last Review Date: 7/2023
Policy Number: C22082-A

Verquvo (vericiguat) Illinois Medicaid Only

PRODUCTS AFFECTED

Verquvo (vericiguat)

COVERAGE POLICY

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.
This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.

Documentation Requirements:
Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

DIAGNOSIS:
Heart Failure

REQUIRED MEDICAL INFORMATION:
A. Heart Failure
1. Documentation that member has a diagnosis of symptomatic chronic heart failure (HF)
AND
2. Member has an ejection fraction (EF) less than 45%
AND
3. Prescriber attests that member has required hospitalization for HF in the previous 6 months or has required the use of IV diuretic in the previous 3 months
AND
4. Member is currently taking or has a documented contraindication or intolerance to both a SGLT-2 inhibitor AND at least ONE of the following:
    a. Angiotensin-II Receptor Blocker/ARBs and Neprilysin Inhibitor Combination (ARNI)
    OR
    b. Angiotensin Converting Enzyme Inhibitor (ACEI)
    OR
    c. Angiotensin-II Receptor Blocker (ARB)

OR

d. Aldosterone antagonist

OR

e. Beta blocker

CONTINUATION OF THERAPY:

A. ALL INDICATIONS:

1. Prescriber attestation of positive clinical response as demonstrated by low disease activity and/or improvements in the condition's signs and symptoms

DURATION OF APPROVAL:

Initial authorization: 12 months, Continuation of Therapy: 12 months

PRESCRIBER REQUIREMENTS:

None

AGE RESTRICTIONS:

18 years or older

QUANTITY: See Illinois Medicaid Drug Formulary or use maximum quantity per FDA label

Maximum Quantity Limits: 10 mg once daily per FDA package labeling

PLACE OF ADMINISTRATION:

The recommendation is that oral medications in this policy will be for pharmacy benefit coverage and patient self-administered.

DRUG INFORMATION

ROUTE OF ADMINISTRATION:

Oral

DRUG CLASS:

Vasoactive Soluble Guanylate Cyclase Stimulator (sGC)

FDA-APPROVED USES:

Verquvo (vericiguat): indicated to reduce the risk of cardiovascular death and heart failure (HF) hospitalization following a hospitalization for heart failure or need for outpatient IV diuretics, in adults with symptomatic chronic HF and ejection fraction less than 45%.

COMPENDIAL APPROVED OFF-LABELED USES:

None

APPENDIX

None

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:
None

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:
All other uses of Verquvo (vericiguat) are considered experimental/investigational and therefore, will follow Molina's Off- Label policy. Contraindications to Verquvo (vericiguat) include: use in patients with concomitant use of other soluble guanylate cyclase (sGC) stimulators and pregnancy.

OTHER SPECIAL CONSIDERATIONS:
The recommended starting dose of Verquvo (vericiguat) is 2.5 mg orally once daily with food. The dose of Verquvo (vericiguat) can be doubles every 2 weeks to reach the target maintenance dose of 10 mg once daily, as tolerated by the patient.

Verquvo (vericiguat) has a black box warning for Embryo-Fetal Toxicity. Do not administer VERQUVO to a pregnant female because it may cause fetal harm. For females of reproductive potential, pregnancy should be excluded before the start of treatment. To prevent pregnancy, females of reproductive potential must use effective forms of contraception during treatment and for one month after stopping treatment.

CODING/BILLING INFORMATION

Note: 1) This list of codes may not be all-inclusive. 2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement

HCPCS CODE	DESCRIPTION
NA	n/a

AVAILABLE DOSAGE FORMS:
Verquvo Tablet 2.5MG
Verquvo Tablet 5MG
Verquvo Tablet 10MG

REFERENCES

1. Illinois HFS Drugs with Stipulated PA Language per Contract for MCOs 7.1.23
2. Verquvo (vericiguat) [prescribing information], Rahway, NJ: Merck Sharp & Dohme Corp., February 2023
3. Illinois Medicaid Preferred Drug List, Effective July 1, 2023