BRITISH COLUMBIA | Ministry of Health

# *SPECIAL AUTHORITY REQUEST*
# VERICIGUAT

HLTH 5832 2024/09/24

**For up-to-date criteria and forms, please check: www.gov.bc.ca/pharmacarespecialauthority**

**Fax requests to 1-800-609-4884 (toll free) OR mail requests to: PharmaCare, Box 9652 Stn Prov Govt, Victoria, BC V8W 9P4**

This facsimile is doctor-patient privileged and contains confidential information intended only for PharmaCare. Any other distribution, copying or disclosure is strictly prohibited.

If PharmaCare approves this Special Authority request, approval is granted solely for the purpose of covering prescription costs. PharmaCare approval does not indicate that the requested device is, or is not, suitable for any specific patient or condition.

If you have received this fax in error, please write MISDIRECTED across the front of the form and fax toll-free to 1-800-609-4884, then destroy the pages received in error.

***Forms with information missing will be returned for completion. If no prescriber fax or mailing address is provided, PharmaCare will be unable to return a response.***

## SECTION 1 – PRESCRIBER'S INFORMATION

Prescriber's Name and Mailing Address

College ID (use ONLY College ID number)

Phone Number (include area code)

**CRITICAL FOR A TIMELY RESPONSE →** Prescriber's Fax Number

## SECTION 2 – PATIENT INFORMATION

Patient (Family) Name

Patient (Given) Name(s)

Date of Birth (yyyy / mm / dd)

Date of Application (yyyy / mm / dd)

**CRITICAL FOR PROCESSING →** Personal Health Number (PHN)

## SECTION 3 – MEDICATION REQUESTED

**VERICIGUAT: 9901-0468**

☐ vericiguat (2.5 mg, 5 mg and 10 mg tablets)

## SECTION 4 – CRITERIA FOR INDEFINITE COVERAGE

**Approval subject to ALL of the criteria below being met (mark boxes and complete blanks as applicable).**

For the treatment of symptomatic chronic heart failure (HF) in adult patients (≥18 years of age) with reduced ejection fraction who are stabilized after a recent decompensation event if all of the following clinical criteria are met:

☐ Patient has heart failure with a left ventricular ejection fraction (LVEF) <45% AND New York Heart Association Class II to IV.

Provide left ventricular ejection fraction (LVEF) (<45%): _____

☐ Patient has had a heart failure decompensation event requiring hospitalization within the last six months or received intravenous (IV) diuretic therapy within the past three months.

Patient will use vericiguat as an adjunct to standard of care* therapy, which includes the following:

☐ An angiotensin-converting enzyme inhibitor (ACEI) OR angiotensin receptor blocker (ARB) OR angiotensin receptor/neprilysin inhibitor (ARNI)

If not, please provide details of intolerance/contraindication to ACEI/ARB/ARNI: _____

**AND** ☐ A beta-blocker (BB)
If not, please provide details of intolerance/contraindication to BB: _____

**AND** ☐ A mineralocorticoid receptor antagonist (MRA)
If not, please provide details of intolerance/contraindication to MRA: _____

**AND** ☐ A sodium-glucose cotransporter-2 inhibitor (SGLT2i)
If not, please provide details of intolerance/contraindication to SGLT2i: _____

* Standard of care for HF is defined as: ACEI/ARB/ARNI and BB and MRA and SGLT2i, unless contraindicated or not tolerated.

**Report all adverse events to the post-market surveillance program, Canadian Vigilance, toll-free 1-866-234-2345 (health professionals only).**

Personal information on this form is collected under the authority of, and in accordance with, the *British Columbia Pharmaceutical Services Act* 22(1) and *Freedom of Information and Protection of Privacy Act* 26 (a),(c),(e). The information is being collected for the purposes of (a) administering the PharmaCare program, (b) analyzing, planning and evaluating the Special Authority and other Ministry programs and (c) to manage and plan for the health system generally. If you have any questions about the collection of this information, call Health Insurance BC from Vancouver at 1-604-683-7151 or from elsewhere in BC toll free at 1-800-663-7100 and ask to consult a pharmacist concerning the Special Authority process.

I have discussed with the patient that the purpose of releasing their information to PharmaCare is to obtain Special Authority for prescription coverage and for the purposes set out here.

_____
Prescriber's Signature (Mandatory)

***PharmaCare may request additional documentation to support this Special Authority request.***
***Actual reimbursement is subject to the rules of a patient's PharmaCare plan, including any annual deductible requirement, and to any other applicable PharmaCare pricing policy.***

## PHARMACARE USE ONLY

| STATUS | EFFECTIVE DATE (YYYY / MM / DD) | DURATION OF APPROVAL |
|---|---|---|
| | | |

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