

## Request for Prior Authorization MAVACAMTEN (CAMZYOS) (PLEASE PRINT – ACCURACY IS IMPORTANT)

Fax Completed Form To 1.833.404.2392 Prescriber Help Desk

1.833.587.2012

Online

covermymeds.com/main/ prior-authorization-forms/

IA Medicaid Member ID #	Patient name	DOB			
Patient address					
Provider NPI	Prescriber name	Phone			
Prescriber address Fax					
Pharmacy name	Address	Phone			
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.					
Pharmacy NPI	Pharmacy fax NDC				

Prior authorization (PA) is required for mavacemten (Camzyos). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

- 1) Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
- 2) Patient has a diagnosis of obstructive hypertrophic cardiomyopathy (HCM); and
- 3) Patient exhibits symptoms of New York Heart Association (NYHA) class II or III symptoms; and
- 4) Is prescribed by or consultation with a cardiologist; and
- 5) Patient has a left ventricular ejection fraction (LVEF)  $\geq$  55%; and
- 6) Patient has a peak left ventricular outflow tract (LVOT) gradient  $\geq$  50 mmHg at rest or with provocation; and
- 7) Documentation of a previous trial and therapy failure, at a maximally tolerated dose, with all of the following:
  - a. Non-vasodilating beta-blocker (atenolol, metoprolol, bisoprolol, propranolol); and
  - b. Non-dihydropyridine calcium channel blocker (verapamil, diltiazem); and
  - c. Combination therapy with disopyramide plus beta-blocker or disopyramide plus a non-dihydropyridine calcium channel blocker.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Request for continuation of therapy will be considered with documentation of a positive response to therapy as evidenced by improvement in obstructive HCM symptoms.

## Non-Preferred

Camzyos				
	Strength	Dosage Instructions	Quantity	Days Supply
Diagnosis:				
Prescriber Sp	oecialty: 🗌 Card	iologist 🔲 Other (specify):		

iowa total care. Request for Prior Authoriz MAVACAMTEN (CAMZY (PLEASE PRINT – ACCURACY IS IN	ration (OS)	Fax Completed Form To 1.833.404.2392 Prescriber Help Desk 1.833.587.2012 Online covermymeds.com/main/ prior-authorization-forms/			
If other, note consultation with cardiologist: Consultation date:					
Physician name, specialty & phone:					
Does patient exhibit symptoms of NYHA class II or III symptom	<b>s?</b> 🗌 No 🗌 Ye	25			
<b>Does patient have LVEF</b> ≥ <b>55%?</b> □ No □ Yes					
<b>Does patient have LVOT gradient</b> $\geq$ <b>50 mmHg at rest or with provocation?</b> No $\Box$ Yes					
Document trials, at a maximally tolerated dose, with all of the	ollowing:				
Non-vasodilating beta-blocker trial (atenolol, metoprolol, bisop	rolol, propranolol):	:			
Drug Name & Dose: Failure reason:					
Non-dihydropyridine calcium channel blocker trial (verapamil,					
Drug Name & Dose:					
Failure reason:					
Combination therapy with disopyramide plus beta-blocker or a blocker:	non-dihydropyridin	ne calcium channel			
Disopyramide Dose:	Trial dates:				
Failure reason:					
Non-vasodilating beta-blocker trial (atenolol, metoprolol, bisoprolol, pro	pranolol):				
Drug Name & Dose:	Trial dates:				
Failure reason:					
OR					
Non-dihydropyridine calcium channel blocker trial (verapamil, diltiazem):					
Failure reason:					
Renewal Requests:					

## Document positive response to therapy as evidenced by improvement in HCM symptoms:

## Attach lab results and other documentation as necessary.

	Prescriber signature (Must match prescriber listed above.)	Date of submission		
<b>IMPORTANT NOTE:</b> In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only.				

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.