HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM
Camzyos™

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 888-509-8142.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for Pharmacy Customer Service for assistance at 855-856-5694

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Camzyos™ (mavacamten)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does documentation show diagnosis of symptomatic obstructive hypertrophic cardiomyopathy (HOCM)?	☐	☐	**Please provide documentation**
2. Is the requesting provider a Heart Failure or Hypertrophic Cardiomyopathy specialist or in consultation with one?	☐	☐	
3. Does documentation show diagnosis of symptomatic New York Heart Association (NYHA) Class II – III obstructive hypertrophic cardiomyopathy with documentation of **ALL** of the following confirming the diagnosis: • **Left ventricular hypertrophy** diagnosed from cardiac imaging and defined as: Maximal left ventricular free wall thickness ≥ 15 mm • **Left Ventricular Outflow Tract (LVOT) obstruction** diagnosed from echocardiographic imaging and defined as: LVOT gradient measured ≥ 50 mmHg at rest or with physiological provocation	☐	☐	**Please provide documentation**
4. Does documentation show documented assessment from echocardiographic imaging indicating baseline left ventricular ejection fraction (LVEF) > 55%?	☐	☐	**Please provide documentation**
5. Does documentation show an adequate trial and failure of ALL of the following at the maximally tolerated FDA-approved dose, unless contraindicated?:	☐	☐	**Please provide documentation**

• at least one prescription strength of non-vasodilating beta-blocker (e.g., atenolol, metoprolol, bisoprolol, propranolol); AND • a non-dihydropyridine calcium channel blocker (e.g., verapamil, diltiazem); AND • disopyramide			
6. Is the requesting provider certified in CAMZYOS Risk Evaluation and Mitigation (REMS) program?	☐	☐	
7. Is the member enrolled and in compliance with CAMZYOS Risk Evaluation and Mitigation (REMS) program?	☐	☐	
8. Does documentation show negative pregnancy test and adherence to a validated form of contraception for duration of therapy (if applicable)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does updated documentation show the member has LVEF of 50% or greater from echocardiographic imaging?	☐	☐	**Please provide documentation**
3. Does updated documentation show the member has responded to therapy identified by an increase in pVO2 OR decrease in Valsalva LVOT gradient OR improvement in NYHA class?	☐	☐	**Please provide documentation**
4. Does updated documentation show the member is in compliance with CAMZYOS REMS program AND ongoing monitoring requirements per package insert?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy: PHARM-HU-143
Origination Date: 07/11/2022
Reviewed/Revised Date: 08/24/2022
Next Review Date: 08/24/2023
Current Effective Date: 09/01/2022