Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Camzyos (mavacamten) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 3 months; Continuation- 6 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Camzyos (mavacamten).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Prescriber is a Cardiologist,
   □ No □ Yes

2. **AND** patient is 18 years of age or older,
   □ No □ Yes

3. **AND** diagnoses with oHCM consistent with current AHA/ACC guidelines and satisfies both of the following:
   - Left ventricular ejection fraction (LVEF) ≥ 55%
   - NYHA class II or III

   □ No □ Yes

4. **AND** peak Valsalva LVOT gradient ≥ 50 mmHg,
   □ No □ Yes

5. **AND** symptomatic oHCM despite highest tolerated dose of a non-vasodilating beta-blocker (or non-dihydropyridine calcium channel blocker if beta-blocker is not tolerated),
   □ No □ Yes

6. **AND** if clinically indicated, consider other AHA/ACC Guideline Class I therapies before mavacamten:
   - Disopyramide
   - Septal reduction therapy for NYHA class III patients

   □ No □ Yes

7. **AND** using effective contraception, if patient is of childbearing potential,
   □ No □ Yes

8. **AND** recommend not to initiative if any of the following situations apply:
   - Known infiltrative or storage disorder causing cardiac hypertrophy that mimics oHCM (e.g. Fabry disease, amyloidosis, or Noonan syndrome with LV hypertrophy)
   - History of syncope or sustained ventricular tachyarrhythmia with exercise within 6 months prior
   - History of resuscitated sudden cardiac arrest (at any time) or known history of appropriate implantable cardioverter defibrillator discharge for life-threatening ventricular arrhythmia within 6 months prior
   - Poorly controlled atrial fibrillation
   - Treatment with disopyramide or ranolazine within 14 days prior to initiation of mavacamten
   - Taking a beta blocker in combination with a calcium channel blocker
   - Successfully treated with invasive septal reduction therapy within 6 months prior
   - QTc interval >500 milliseconds

   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. LVEF remains ≥ 50%,
   □ No □ Yes

2. **AND** patient has not developed heart failure symptoms or worsening clinical status,
   □ No □ Yes

3. **AND** patient is adherent to labs and monitoring as required by the REMS program (e.g. ECHO with Valsalva LVOT gradient, NYHA classification at least every 12 weeks),
   □ No □ Yes

4. **AND** patient continues to be managed by Cardiologist with expertise in hypertrophic cardiomyopathy
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**