AmeriHealth Caritas North Carolina

# Pharmacy Request for Prior Approval – Camzyos

**Beneficiary Information**

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

**Prescriber Information**

7. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
8. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

**Drug Information**

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

**Clinical Information**

**Initial Requests for Camzyos: (questions 1-10)**

1. Is the beneficiary 18 years of age or older? Yes___ No___
2. Does the beneficiary have a diagnosis of obstructive hypertrophic cardiomyopathy (oHCM) consistent with current guidelines (e.g., American College of Cardiology Foundation/American Heart Association, European Society of Cardiology guidelines)? Yes___ No___
3. Does the beneficiary have New York Heart Association (NYHA) Class 2 or Class 3? Yes___ No___
4. Will the beneficiary be monitored for LVEF, Valsalva left ventricular outflow tract (LVOT) gradient assessment, and heart failure symptoms (e.g., shortness of breath, chest pain, arrhythmia, heart palpitations, fatigue, swelling in the legs)? Yes___ No___
5. Does the beneficiary have adequate echocardiogram or cardiovascular magnetic resonance imaging (CMR)? Yes___ No___
6. Will the beneficiary avoid concomitant use with moderate to strong CYP2C19 inhibitors, strong CYP3A4 inhibitors, and moderate to strong CYP2C19 and CYP3A4 inducers (e.g., carbamazepine, cimetidine, esomeprazole, omeprazole, phenobarbital, phenytoin, rifampin, St. John's wort)? Yes___ No___
7. For females of childbearing potential, has a pregnancy test been performed ensuring beneficiary is not pregnant? Yes___ No___
8. Will Mavacamten be prescribed by or in consultation with a cardiologist? Yes___ No___
9. Has the beneficiary had an adequate trial and failure of ≥ 1 beta-blocker? Yes___ No___ List:_____
10. Does the beneficiary have documented left ventricular ejection fraction (LVEF) ≥ 55%? **(for initiation of treatment only)** Yes___ No___

**Continuation Requests for Camzyos: (questions 1-9 above and 11-13)**

11. Has the beneficiary had disease improvement and/or stabilization of disease from baseline (e.g., NYHA class improvement [class 3 to class 2], ≥ 1.5 mL/kg/min in pVO2 increase or ≥ 3 mL/kg/min in pVO2 without NYHA class worsening)? Yes___ No___
12. Does the beneficiary have left ventricular ejection fraction (LVEF) ≥ 50%? Yes___ No___
13. Has the beneficiary experienced any treatment-restricting adverse effects (e.g., heart failure)? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

**Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406**