NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Camzyos

Beneficiary Information

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

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext._____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

Requests for Camzyos (Initial questions 1-10):

1. Is the beneficiary 18 years of age or older? ☐ **Yes** ☐ **No**

2. Does the beneficiary has 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**

Requests for Camzyos (Continuation 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 (800) 678-3189

Pharmacy PA Call Center: (866) 799-5318