# US Family Health Plan
# Prior Authorization Request Form for

# mavacamten (Camzyos)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
**Attn: Pharmacy, 77 Warren St, Brighton, MA 02135**

QUESTIONS? **Call 1-877-880-7007**

**Prior authorization approval expires after 1 year. For renewal of therapy an initial Tricare prior authorization approval is required.**

**Step 1**

**Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

**Step 2**

**Please complete the clinical assessment:**

| | | |
|---|---|---|
| **1. Has the patient received this medication under the TRICARE benefit in the last 6 months?**<br>**Please choose "No" if the patient did not previously have a TRICARE approved PA for Camzyos** | ☐ Yes<br>(subject to verification)<br>Proceed to question **2** | ☐ No<br>Proceed to question **3** |
| **2. Has the patient responded to therapy, as evidenced by improvement in obstructive hypertrophic cardiomyopathy symptoms?** | ☐ Yes<br>Sign and date below | ☐ No<br>**STOP**<br>Coverage not approved |
| **3. Is the patient greater than or equal to 18 years of age?** | ☐ Yes<br>Proceed to question **4** | ☐ No<br>**STOP**<br>Coverage not approved |
| **4. Is the requested medication prescribed by a cardiologist?** | ☐ Yes<br>Proceed to question **5** | ☐ No<br>**STOP**<br>Coverage not approved |
| **5. Does the patient have documented evidence of obstructive hypertrophic cardiomyopathy (HCM)?** | ☐ Yes<br>Proceed to question **6** | ☐ No<br>**STOP**<br>Coverage not approved |
| **6. Is the left ventricular outflow tract (LVOT) pressure greater than or equal to 50 mmHg?** | ☐ Yes<br>Proceed to question **7** | ☐ No<br>**STOP**<br>Coverage not approved |
| **7. Does the patient have New York Heart Association (NYHA) Class II to III obstructive hypertrophic cardiomyopathy that is symptomatic (for example; dyspnea, chest pain, light headedness, syncope, fatigue, reduced exercise capacity)?** | ☐ Yes<br>Proceed to question **8** | ☐ No<br>**STOP**<br>Coverage not approved |

| | | |
|---|---|---|
| **8. Is the left ventricular ejection fraction (LVEF) greater than or equal to 55%?** | ☐ Yes<br>Proceed to question **9** | ☐ No<br>**STOP**<br>Coverage not approved |
| **9. Has the patient failed therapy with at least one agent from both classes:**<br>• **beta blocker (non-vasodilating) propranolol, metoprolol AND**<br>• **calcium channel blockers (non-dihydropyridine) verapamil or diltiazem?** | ☐ Yes<br>Proceed to question **10** | ☐ No<br>**STOP**<br>Coverage not approved |
| **10. Is the patient on dual calcium channel blocker and beta blocker therapy concurrently?** | ☐ Yes<br>**STOP**<br>Coverage not approved | ☐ No<br>Proceed to question **11** |
| **11. Is the patient receiving ranolazine (Ranexa) or disopyramide (Norpace, Rythmodan) concurrently?** | ☐ Yes<br>**STOP**<br>Coverage not approved | ☐ No<br>Proceed to question **12** |
| **12. What is the patient's sex?** | ☐ Female<br>Proceed to question **13** | ☐ Male<br>Proceed to question **16** |
| **13. Is the patient of childbearing potential?** | ☐ Yes<br>Proceed to question **14** | ☐ No<br>Proceed to question **16** |
| **14. Has the patient received counseling for using effective contraception during therapy with Camzyos and for 4 months after the last dose?** | ☐ Yes<br>Proceed to question **15** | ☐ No<br>**STOP**<br>Coverage not approved |
| **15. Is the patient pregnant?** | ☐ Yes<br>**STOP**<br>Coverage not approved | ☐ No<br>Proceed to question **16** |
| **16. Are the patient and provider aware of the risks of systolic dysfunction, as outlined in the REMS program?** | ☐ Yes<br>Proceed to question **17** | ☐ No<br>**STOP**<br>Coverage not approved |
| **17. Will the patient and the provider agree to comply to all requirements of the REMS program, including echocardiogram at 0, 4, 8, 12 weeks follow by every 12 weeks and drug interaction monitoring requirements?** | ☐ Yes<br>Sign and date below | ☐ No<br>**STOP**<br>Coverage not approved |

**Step 3** **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____