



9/9/2026	<%PANumber%>
Prior Authorization	
Internal Use Only	
JOHNS HOPKINS HEALTH PLANS Camzyos - Priority Partners MCO This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at 1-410-424-4607 . Please contact Johns Hopkins Health Plans at 1-888-819-1043 with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Camzyos - Priority Partners MCO.	

Drug Name (select from list of drugs shown)		
Camzyos (mavacamten)		
Quantity	Frequency	Strength
Route of Administration	Expected Length of Therapy	

Patient Information	
Patient Name:	_____
Patient ID:	_____
Patient Group No.:	_____
Patient DOB:	_____
Patient Phone:	_____

Prescribing Physician	
Physician Name:	_____
Physician Phone:	_____
Physician Fax:	_____
Physician Address:	_____
City, State, Zip:	_____

Diagnosis: _____	ICD Code: _____
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Comments: _____

Please circle the appropriate answer for each question.			
1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	<table border="1" style="display: inline-table;"><tr><td style="width: 50%; text-align: center;">Y</td><td style="width: 50%; text-align: center;">N</td></tr></table>	Y	N
Y	N		

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	
[If yes, skip to question 12.]	
2. Does the patient have a diagnosis of symptomatic obstructive cardiomyopathy (HCM) confirmed by echocardiogram or cardiac magnetic resonance?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
3. Is the diagnosis due to a known infiltrative or storage disorder causing cardiac hypertrophy that mimicked obstructive HCM (i.e., Fabry disease, amyloidosis, or Noonan syndrome with left ventricular hypertrophy)?	Y N
NOTE: Submission of medical records is required.	
[If yes, no further questions.]	
4. Is the patient 18 years of age or older?	Y N
[If no, no further questions.]	
5. Does the patient have a New York Heart Association (NYHA) Class II or III functional status?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
6. Does the patient have a left ventricular ejection fraction (LVEF) of greater than or equal to 55%?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
7. Does the patient have a left ventricular outflow tract (LVOT) peak gradient of greater than or equal to 50 mmHg at rest or with provocation?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
8. Has the patient had a trial and an inadequate response to both of the following: A) Non-vasodilating beta blocker (i.e., atenolol, bisoprolol, metoprolol), and B) Non-dihydropyridine calcium channel blocker (verapamil, diltiazem)?	Y N
NOTE: Submission of medical records is required.	
[If yes, skip to question 10.]	
9. Is there a clinical reason why the following cannot be used by the patient: A) Non-vasodilating beta blocker (i.e., atenolol, bisoprolol, metoprolol), and B) Non-dihydropyridine calcium channel blocker (verapamil, diltiazem)?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	

10. Will the requested medication be used in combination with the following: A) Moderate to strong CYP2C19 inhibitors or strong CYP3A4 inhibitors, or B) Moderate to strong CYP2C19 inducers or moderate to strong CYP3A4 inducers?	Y N
[If yes, no further questions.]	
11. Will the requested medication be used for any indication or use that is not Food and Drug Administration (FDA)-approved or guidelines-supported?	Y N
[No further questions.]	
12. Is there a new echocardiogram left ventricular ejection fraction (LVEF) assessment?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
13. Is there documentation showing the patient has had a positive response to treatment?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
14. Does the patient have left ventricular ejection fraction (LVEF) less than 50%, symptomatic heart failure, or worsening clinical status?	Y N
NOTE: Submission of medical records is required.	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date