TRICARE Prior Authorization Request Form for
mavacamten (Camzyos)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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? **Please choose "No" if the patient did not previously have a TRICARE approved PA for Camzyos**	☐ Yes (subject to verification) Proceed to question **2**	☐ No Proceed to question **3**
2. Has the patient responded to therapy, as evidenced by improvement in obstructive hypertrophic cardiomyopathy symptoms?	☐ Yes Sign and date below	☐ No **STOP** Coverage not approved
3. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Is the requested medication prescribed by a cardiologist?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Does the patient have documented evidence of obstructive hypertrophic cardiomyopathy (HCM)?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved
6. Is the left ventricular outflow tract (LVOT) pressure greater than or equal to 50 mmHg?	☐ Yes Proceed to question **7**	☐ No **STOP** 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 Proceed to question **8**	☐ No **STOP** Coverage not approved

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8. Is the left ventricular ejection fraction (LVEF) greater than or equal to 55%?	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved
9. Has the patient failed therapy with at least one agent from both classes: • **beta blocker (non-vasodilating) propranolol, metoprolol AND** • **calcium channel blockers (non-dihydropyridine) verapamil or diltiazem?**	☐ Yes Proceed to question **10**	☐ No **STOP** Coverage not approved
10. Is the patient on dual calcium channel blocker and beta blocker therapy concurrently?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **11**
11. Is the patient receiving ranolazine (Ranexa) or disopyramide (Norpace, Rythmodan) concurrently?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **12**
12. What is the patient's gender?	☐ Female Proceed to question **13**	☐ Male Proceed to question **16**
13. Is the patient of childbearing potential?	☐ Yes Proceed to question **14**	☐ No 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 Proceed to question **15**	☐ No **STOP** Coverage not approved
15. Is the patient pregnant?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **16**
16. Are the patient and provider aware of the risks of systolic dysfunction, as outlined in the REMS program?	☐ Yes Proceed to question **17**	☐ No **STOP** 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 Sign and date below	☐ No **STOP** Coverage not approved

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

_____ _____

Prescriber Signature Date

[09 November 2022]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#: