MOLINA HEALTHCARE

Iowa Health Link IOWA HHS Hawki Iowa HHS

Request for Prior Authorization

FAX Completed Form To
1 (877) 733-3195
Provider Help Desk
1 (844) 236-1464

MAVACAMTEN (CAMZYOS)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for mavacemten (Camzyos). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1) **Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and**
2) **Patient has a diagnosis of obstructive hypertrophic cardiomyopathy (HCM); and**
3) **Patient exhibits symptoms of New York Heart Association (NYHA) class II or III symptoms; and**
4) **Is prescribed by or consultation with a cardiologist; and**
5) **Patient has a left ventricular ejection fraction (LVEF) ≥ 55%; and**
6) **Patient has a peak left ventricular outflow tract (LVOT) gradient ≥ 50 mmHg at rest or with provocation; and**
7) **Documentation of a previous trial and therapy failure, at a maximally tolerated dose, with all of the following:**
   a. **Non-vasodilating beta-blocker (atenolol, metoprolol, bisoprolol, propranolol); and**
   b. **Non-dihydropyridine calcium channel blocker (verapamil, diltiazem); and**
   c. **Combination therapy with disopyramide plus beta-blocker or disopyramide plus a non-dihydropyridine calcium channel blocker.**

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Request for continuation of therapy will be considered with documentation of a positive response to therapy as evidenced by improvement in obstructive HCM symptoms.

Non-Preferred

☐ Camzyos

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis: _____

Prescriber Specialty: ☐ Cardiologist ☐ Other (specify): _____

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MAVACAMTEN (CAMZYOS)

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If other, note consultation with cardiologist: Consultation date: _____

Physician name, specialty & phone: _____

Does patient exhibit symptoms of NYHA class II or III symptoms? ☐ No ☐ Yes

Does patient have LVEF ≥ 55%? ☐ No ☐ Yes

Does patient have LVOT gradient ≥ 50 mmHg at rest or with provocation? ☐ No ☐ Yes

Document trials, at a maximally tolerated dose, with all of the following:

Non-vasodilating beta-blocker trial (atenolol, metoprolol, bisoprolol, propranolol):

Drug Name & Dose:_____ Trial dates:_____

Failure reason:_____

Non-dihydropyridine calcium channel blocker trial (verapamil, diltiazem):

Drug Name & Dose:_____ Trial dates:_____

Failure reason:_____

Combination therapy with disopyramide plus beta-blocker or a non-dihydropyridine calcium channel blocker:

Disopyramide Dose:_____ Trial dates:_____

Failure reason:_____

Non-vasodilating beta-blocker trial (atenolol, metoprolol, bisoprolol, propranolol):

Drug Name & Dose:_____ Trial dates:_____

Failure reason:_____

OR

Non-dihydropyridine calcium channel blocker trial (verapamil, diltiazem):

Drug Name & Dose:_____ Trial dates:_____

Failure reason:_____

<u>Renewal Requests:</u>

Document positive response to therapy as evidenced by improvement in HCM symptoms:

_____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*