Camzyos (mavacamten)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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Last Updated: 10.15.26

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ obstructive hypertrophic cardiomyopathy(oHCM) ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:
Initial Request:

Is the drug going to be used in conjunction with a clinical trial? ☐ Yes ☐ No

Does the patient weigh 30kg or more? ☐ Yes ☐ No Please submit documentation.

Will patient use Camzyos(mavacamten) in combination with Myqorzo(afacamten)? ☐ Yes ☐ No

Is prescriber a cardiologist or pulmonologist? ☐ Yes ☐ No

Is patient greater than or equal to 45kg(99.2lbs)? ☐ Yes ☐ No

Does patient have a documented left ventricular ejection fraction (LVEF) ≥55%? ☐ Yes ☐ No Please submit documentation.

Is patient NYHA Class II or III? ☐ Yes ☐ No

Has patient tried beta blocker for at least 1 month or has failed treatment with, or had an intolerance to, beta blocker? ☐ Yes ☐ No

Does patient have a documented oxygen saturation at rest ≥90%? ☐ Yes ☐ No Please submit documentation.

Does patient have a known infiltrative or storage disorder causing cardiac hypertrophy that mimics oHCM, such as Fabry disease, amyloidosis, or Noonan syndrome with LV hypertrophy? ☐ Yes ☐ No

Does patient have paroxysmal, intermittent atrial fibrillation with atrial fibrillation prior to starting Camzyos(mavacamten)? ☐ Yes ☐ No

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Does patient have persistent or permanent atrial fibrillation and/or the rate has not been adequately controlled within 6 months prior to starting Camzyos(maracatu)? □ Yes □ No

Has patient been successfully treated with invasive septal reduction (surgical myectomy or percutaneous alcohol septal ablation [ASA]) within 6 months prior to starting Camzyos(mavacamten)? □ Yes □ No Please provide documentation.

Are there plans to have either of these treatments invasive septal reduction (surgical myectomy or percutaneous alcohol septal ablation [ASA]) during treatment with Camzyos(mavacamten)? □ Yes □ No

Renewal Request:

Is prescriber a cardiologist or pulmonologist? □ Yes □ No

Is patient continuing to demonstrate a positive clinical response? □ Yes □ No Please provide documentation.

Will patient use Camzyos(mavacamten) in combination with Myqorzo(afacamten)? □ Yes □ No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

***Please note:** Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

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FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

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