

**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](http://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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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<b>1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
<b>MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):</b> _____	<b>DURATION OF THERAPY (SPECIFY DATES):</b> _____	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b> _____
<b>2. LIST DIAGNOSES:</b> <input type="checkbox"/> obstructive hypertrophic cardiomyopathy(oHCM) <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____		<b>ICD-10:</b> _____
<b>3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.</b>		
<b>Clinical Information:</b> <b>Initial Request:</b> Is the drug going to be used in conjunction with a clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No Will patient use Camzyos(mavacamten) in combination with Myqorzo(afacamten)? <input type="checkbox"/> Yes <input type="checkbox"/> No Is prescriber a cardiologist or pulmonologist? <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient greater than or equal to 45kg(99.2lbs)? <input type="checkbox"/> Yes <input type="checkbox"/> No Does patient have a documented left ventricular ejection fraction (LVEF) $\geq 55\%$ ? <input type="checkbox"/> Yes <input type="checkbox"/> No Please submit documentation. Is patient NYHA Class II or III? <input type="checkbox"/> Yes <input type="checkbox"/> No Has patient tried beta blocker for at least 1 month or has failed treatment with, or had an intolerance to, beta blocker? <input type="checkbox"/> Yes <input type="checkbox"/> No Does patient have a documented oxygen saturation at rest $\geq 90\%$ ? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Does patient have paroxysmal, intermittent atrial fibrillation with atrial fibrillation prior to starting Camzyos(mavacamten)? <input type="checkbox"/> Yes <input type="checkbox"/> No 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No		

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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?

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**\*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:** \_\_\_\_\_

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**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