

Myqorzo (afacamten)
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:
REQUESTER (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):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?		
<input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> obstructive hypertrophic cardiomyopathy(oHCM)		
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s):		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
Is patient going to be using drug in combination with a clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Initial Request: Is prescriber a cardiologist or pulmonologist? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does patient have a Body mass index < 35 kg/m2? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i>		
Will patient use Myqorzo(aficamten) in combination with Camzyos(mavacamten)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does patient have LV hypertrophy and non-dilated LV chamber in the absence of other cardiac disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i>		
Does patient have an end-diastolic LV wall thickness as measured by echocardiography of one of the below? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i> <input type="checkbox"/> ≥15 mm in one or more myocardial segments OR <input type="checkbox"/> ≥13 mm in one or more wall segments and a known-disease-causing gene mutation or positive family history of HCM		
Does patient have a resting LVOT-G ≥30 mm Hg and post-Valsalva LVOT-G ≥50 mmHg as determined by the echocardiography? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i>		
Does patient have a LVEF ≥60% ? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i>		
Does patient have New York Heart Association (NYHA) Functional Class II or III? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does patient have a Respiratory exchange ratio (RER) ≥1.05 AND/OR a pVO2 ≤90% predicted? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i>		
Does patient have significant valvular heart disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i>		
Does patient have moderate-severe valvular aortic stenosis and/or regurgitation? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i>		



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Does patient have moderate-severe mitral regurgitation not due to systolic anterior motion of the mitral valve? Yes No *Please submit documentation.*

Does patient have known or suspected infiltrative, genetic or storage disorder causing cardiac hypertrophy that mimics oHCM (eg, Noonan syndrome, Fabry disease, amyloidosis)? Yes No *Please submit documentation.*

Has patient been treated with septal reduction therapy (surgical myectomy or percutaneous alcohol septal ablation)? Yes No *Please submit documentation.*

Does patient have an inability to exercise on a treadmill or bicycle (eg, orthopedic limitations)? Yes No *Please submit documentation.*

Has patient received prior treatment with aficamten or mavacamten(Camzyos)? Yes No *Please submit documentation.*

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/diagnosis 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

Phone: 877-228-7909