

**NC Medicaid and NC Health Choice  
Pharmacy Prior Approval Request for  
Camzyos**



**Beneficiary Information**

1. Beneficiary Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
3. Beneficiary ID #: \_\_\_\_\_ 4. Beneficiary Date of Birth: \_\_\_\_\_ 5. Beneficiary Gender: \_\_\_\_\_

**Prescriber Information**

6. Prescribing Provider NPI #: \_\_\_\_\_  
7. Requester Contact Information - Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

**Drug Information**

8. Drug Name: \_\_\_\_\_ 9. Strength: \_\_\_\_\_ 10. Quantity Per 30 Days: \_\_\_\_\_  
11. Length of Therapy (in days):  up to 30 Days  60 Days  90 Days  120 Days  180 Days  365 Days  Other \_\_\_\_\_

**Clinical Information**

**Requests for Camzyos (Initial questions 1-10):**

1. Is the beneficiary 18 years of age or older?  Yes  No
2. Does the beneficiary has a diagnosis of obstructive hypertrophic cardiomyopathy (oHCM) consistent with current guidelines (e.g., American College of Cardiology Foundation/American Heart Association, European Society of Cardiology guidelines)?  Yes  No
3. Does the beneficiary have New York Heart Association (NYHA) Class 2 or Class 3?  Yes  No
4. Will the beneficiary be monitored for LVEF, Valsalva left ventricular outflow tract (LVOT) gradient assessment, and heart failure symptoms (e.g., shortness of breath, chest pain, arrhythmia, heart palpitations, fatigue, swelling in the legs)?  Yes  No
5. Does the beneficiary have adequate echocardiogram or cardiovascular magnetic resonance imaging (CMR)?  Yes  No
6. Will the beneficiary avoid concomitant use with moderate to strong CYP2C19 inhibitors, strong CYP3A4 inhibitors, and moderate to strong CYP2C19 and CYP3A4 inducers (e.g., carbamazepine, cimetidine, esomeprazole, omeprazole, phenobarbital, phenytoin, rifampin, St. John's wort)?  Yes  No
7. For females of childbearing potential, has a pregnancy test been performed ensuring beneficiary is not pregnant?  Yes  No
8. Will Mavacamten be prescribed by or in consultation with a cardiologist?  Yes  No
9. Has the beneficiary had an adequate trial and failure of  $\geq 1$  beta-blocker ?  Yes  No List: \_\_\_\_\_
10. Does the beneficiary have documented left ventricular ejection fraction (LVEF)  $\geq 55\%$  (for initiation of treatment only)?  Yes  No

**Requests for Camzyos (Continuation 1-9 above and 11-13):**

11. Has the beneficiary had disease improvement and/or stabilization of disease from baseline (e.g., NYHA class improvement [class 3 to class 2],  $\geq 1.5$  mL/kg/min in pVO<sub>2</sub> increase or  $\geq 3$  mL/kg/min in pVO<sub>2</sub> without NYHA class worsening)?  Yes  No
12. Does the beneficiary have left ventricular ejection fraction (LVEF)  $\geq 50\%$ ?  Yes  No
13. Has the beneficiary experienced any treatment-restricting adverse effects (e.g., heart failure)?  Yes  No

Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_

**(Prescriber Signature Mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.