



**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	
<b>LAST NAME:</b>	<b>FIRST NAME:</b>
<b>PHONE NUMBER:</b>	<b>DATE OF BIRTH:</b>
<b>STREET ADDRESS:</b>	
<b>CITY:</b>	<b>STATE:</b> <b>ZIP CODE:</b>
<b>PATIENT INSURANCE ID NUMBER:</b>	

**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: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI\\_DISCLOSURE\\_AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

**PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):** \_\_\_\_\_  
**AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:** \_\_\_\_\_

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

MEDICATION OR MEDICAL DISPENSING INFORMATION			
<b>MEDICATION NAME:</b>			
<b>DOSE/STRENGTH:</b>	<b>FREQUENCY:</b>	<b>LENGTH OF THERAPY/REFILLS:</b>	<b>QUANTITY:</b>
<input type="checkbox"/> <b>NEW THERAPY</b>	<input type="checkbox"/> <b>RENEWAL</b>	<b>IF RENEWAL: DATE THERAPY INITIATED:</b>	
<b>DURATION OF THERAPY (SPECIFIC DATES):</b>			

*Continued on next page.*





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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:**

<input type="checkbox"/> obstructive hypertrophic cardiomyopathy(oHCM)  <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____	
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**3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.**

**Clinical Information:**  
 Is the drug going to be used in conjunction with a clinical trial?  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 a history of syncope or sustained ventricular tachyarrhythmia with exercise within 6 months prior to starting Camzyos(mavacamten)?  Yes  No Please submit documentation.

Does patient have history of resuscitated sudden cardiac arrest (at any time) or known history of appropriate implantable cardioverter defibrillator (ICD) discharge for life-threatening ventricular arrhythmia within 6 months prior to starting Camzyos(mavacamten)?  Yes  No

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





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**Has patient been treated within 14 days prior to starting Camzyos(mavacamten) with disopyramide or ranolazine?**

**Are there plans for treatment with disopyramide or ranolazine during treatment with Camzyos(mavacamten)?**  Yes  No **Please submit documentation.**

**Has patient been treated within 14 days prior to starting Camzyos(mavacamten) with a combination of  $\beta$ -blockers and calcium channel blockers?**  Yes  No

**Are there plans for treatment with a combination of  $\beta$ -blockers and calcium channel blockers, during the treatment with Camzyos(mavacamten)?**  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

**Has patient had an ICD placement within 2 months prior to starting Camzyos(mavacamten)?**  Yes  No

**Are there plans to have an ICD placement during treatment with Camzyos(mavacamten)?**  Yes  No **Please provide documentation.**

**Has patient had prior treatment with cardiotoxic agents such as doxorubicin or similar?**  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:** \_\_\_\_\_

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**FAX THIS FORM TO: 800-424-7640**

**MAIL REQUESTS TO:** Magellan Rx Management Prior Authorization Program

Attn: CP – 4201

P.O. Box 64811

St. Paul, MN 55164-0811

