

# AvMed

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST\*

**Directions:** The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-305-671-0200.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

### Cardiac Myosin Inhibitors

**Drug Requested:** (select drug below)

<input type="checkbox"/> <b>Camzyos<sup>®</sup></b> (mavacamten)	<input type="checkbox"/> <b>Myqorzo<sup>™</sup></b> (aficamten)
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**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

Member Name: \_\_\_\_\_  
Member AvMed #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Prescriber Name: \_\_\_\_\_  
Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Office Contact Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
NPI #: \_\_\_\_\_

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

Drug Form/Strength: \_\_\_\_\_  
Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_  
Weight (if applicable): \_\_\_\_\_ Date weight obtained: \_\_\_\_\_

**Quantity limit:** 1 capsule or 1 tablet per day

**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

**Initial Authorization: 12 months**

- Member is 18 years of age or older
- Prescribed by a cardiologist

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- Member has a diagnosis of symptomatic obstructive hypertrophic cardiomyopathy (oHCM)
- Member had an adequate echocardiogram or cardiovascular magnetic resonance imaging (CMR)
- Member has evidence of maximal left ventricular wall thickness that meets **ONE** of the following (**submit documentation**):
  - Left ventricular wall thickness  $\geq 15$  mm
  - Left ventricular wall thickness  $\geq 13$  mm in the presence of positive genetic testing or family history of oHCM
- Member has New York Heart Association (NYHA) class II-III symptoms (**submit documentation**)
- Member has documented left ventricular ejection fraction (LVEF)  $\geq 55\%$
- Member has documented left ventricular outflow track (LVOT) gradient of 50 mmHg or higher (at rest or with provocation/Valsalva)
- Member remains symptomatic despite a trial of **TWO** of the following, or the member is intolerant to all or unable to use any (**verified by chart notes or pharmacy paid claims; failure of medications must be after titration to a dose where symptom benefit is observed**):
  - Non-vasodilating beta-blocker (e.g., atenolol, metoprolol, carvedilol, propranolol)
  - Non-dihydropyridine calcium channel blocker (e.g., verapamil or diltiazem)
  - Disopyramide (as add-on to beta-blocker or non-dihydropyridine calcium channel blocker)
  - Septal reduction therapy
- Member meets **BOTH** of the following:
  - No history of septal reduction therapy in the past six months
  - No current plans for septal reduction therapy
- Member will **NOT** use the requested drug together with moderate to strong CYP2C19 inhibitors/inducers and strong CYP3A4 inhibitors/inducers (Camzyos requests), or with rifampin (Myqorzo requests)
- Provider is enrolled in the requested drug's REMS program and will adhere to all REMS requirements including appropriate dose titration based on echocardiogram results and monitoring for drug interactions and adverse events
- Provider has submitted at least **ONE** of the following baseline assessments of the member's symptoms associated with oHCM or functional status:
  - peak oxygen consumption ( $pVO_2$ ) measured by CPET
  - Kansas City Cardiomyopathy Questionnaire score
  - NYHA functional class

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**Reauthorization: 12 months.** All criteria that apply must be checked for approval. To support each line checked, all documentation (lab results, diagnostics, and/or chart notes) must be provided or request may be denied.

- Member must have improvement in symptoms or functional status from baseline (or stabilization from last reauthorization) demonstrated by at least **ONE** of the following (**submit documentation of symptom and/or test result improvement from baseline**):
  - peak oxygen consumption (pVO<sub>2</sub>) measured by CPET
  - Kansas City Cardiomyopathy Questionnaire score
  - NYHA functional class
- Provider has submitted results of the member's most recent echocardiogram obtained after starting the requested medication (**NOTE**: REMS programs require echocardiograms every 3 or 6 months after reaching a stable dose, or more frequently during dose adjustments)
- Member's LVEF remains  $\geq 50\%$

**Medication being provided by a Specialty Pharmacy – Proprium Rx**

***\*\*Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.\*\****  
***\*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.\****