Louisiana Medicaid
Mavacamten (Camzyos™)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for mavacamten (Camzyos™).

Additional Point-of-Sale edits may apply.

*This agent may have **Black Box Warnings**, and/or may be subject to **Risk Evaluation and Mitigation Strategy (REMS)** under FDA safety regulations. Please refer to individual prescribing information for details.*

Approval Criteria

- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of obstructive hypertrophic cardiomyopathy (HCM); **AND**
- Obstructive HCM for this recipient is symptomatic New York Heart Association (NYHA) Class II or III [must be **stated on the request**]; **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a cardiologist; **AND**
- The recipient has had an inadequate response, intolerance, adverse reaction, or contraindication to beta blockers or calcium channel blockers (medication name and treatment dates must be **stated on the request**); **AND**
- The recipient has a documented left ventricular ejection fraction (LVEF) ≥ 55% prior to initiation of mavacamten (LVEF value must be **stated on the request**); **AND**
- If request is for a non-preferred agent **– ONE** of the following is required:
    - The recipient has had a *treatment failure* with at least one preferred product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
    - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated; **AND**
- By submitting the authorization request, the prescriber attests to the following:
    - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
    - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
    - The recipient has no concomitant drug therapies or disease states that limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling.

Duration of initial approval: 6 months

Reauthorization Criteria

- The recipient continues to meet initial criteria; **AND**
- The prescriber **states on the request** that the recipient has evidence of a positive response to therapy; **AND**
- The prescriber **states on the request** that the recipient is being monitored for left ventricular ejection fraction (LVEF), Valsalva left ventricular outflow tract (LVOT) gradient assessment, and heart failure symptoms and has not developed any contraindications or other adverse drug effects that may exclude continued use.

Duration of reauthorization approval: 12 months

References

Camzyos (mavacamten) [package insert]. Brisbane, CA: MyoKardia, Inc; May 2022. https://packageinserts.bms.com/pi/pi_camzyos.pdf

Ommen SR, Mital S, Burke MA, et al. 2020 AHA/ACC Guideline for the Diagnosis and Treatment of Patients With Hypertrophic Cardiomyopathy: Executive Summary: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *J Am Coll Cardiol*. 2020;76(25):3022-3055. doi:10.1016/j.jacc.2020.08.044

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