Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Camzyos

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name:_____ 2. Strength: _____ 3. Quantity per 30 Days: _____
4. 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 member 18 years of age or older? ☐ **Yes** ☐ **No**
2. Does the member 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 member have New York Heart Association (NYHA) Class 2 or Class 3? ☐ **Yes** ☐ **No**
4. Will the member 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 member have adequate echocardiogram or cardiovascular magnetic resonance imaging (CMR)? ☐ **Yes** ☐ **No**
6. Will the member 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 member is not pregnant? ☐ **Yes** ☐ **No**
8. Will Mavacamten be prescribed by or in consultation with a cardiologist? ☐ **Yes** ☐ **No**
9. Has the member had an adequate trial and failure of ≥ 1 beta-blocker? ☐ **Yes** ☐ **No** List: _____
10. Does the member have documented left ventricular ejection fraction (LVEF) ≥ 55% (for initiation of treatment only)? ☐ **Yes** ☐ **No**

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

11. Has the member had disease improvement and/or stabilization of disease from baseline (e.g., NYHA class improvement [class 3 to class 2], ≥ 1.5 mL/kg/min in pVO2 increase or ≥ 3 mL/kg/min in pVO2 without NYHA class worsening)? ☐ **Yes** ☐ **No**
12. Does the member have left ventricular ejection fraction (LVEF) ≥ 50%? ☐ **Yes** ☐ **No**
13. Has the member 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.

Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277