UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 2281-4
Program	Prior Authorization/Medical Necessity
Medication	Camzyos® (mavacamten)
P&T Approval Date	7/2022, 11/2022, 8/2023, 8/2024
Effective Date	11/1/2024

1. Background:

Camzyos® (mavacamten) is a cardiac myosin inhibitor indicated for the treatment of adults with symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy (HCM) to improve functional capacity and symptoms.[1]

2. Coverage Criteria[a]:

A. **Initial Authorization**

1. **Camzyos** will be approved based on **all** of the following criteria:

   a. Diagnosis of obstructive hypertrophic cardiomyopathy (HCM)

   -AND-

   b. Heart failure is classified as **one** of the following:

      (1) New York Heart Association (NYHA) class II heart failure

      -OR-

      (2) New York Heart Association (NYHA) class III heart failure

   -AND-

   c. Patient has a left ventricular ejection fraction of greater than or equal to 55%

   -AND-

   d. Patient has a Valsalva left ventricular outflow tract (LVOT) peak gradient greater than or equal to 50 mmHg at rest or with provocation

   -AND-

   e. History of inadequate response, intolerance, failure, or contraindication to two of the following at a maximally tolerated dose[2,3]:

      (1) Non-vasodilating beta blocker (e.g., atenolol, bisoprolol, metoprolol, nadolol, propranolol)
      (2) Nondihydropyridine calcium channel blocker (i.e., diltiazem, verapamil)

(3) Disopyramide

-AND-

f. Prescribed by or in consultation with a cardiologist

Authorization will be issued for 12 months

B. <u>Reauthorization</u>

1. **Camzyos** will be approved based on **<u>all</u>** of the following criteria:

   a. Documentation of positive clinical response to therapy as supported by **<u>one</u>** of the following:

      (1) Reduction in NYHA class

      -OR-

      (2) No worsening in NYHA class

      -AND-

   b. Patient has a left ventricular ejection fraction of greater than or equal to 50%

      -AND-

   c. Prescribed by or in consultation with a cardiologist

   Authorization will be issued for 12 months

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits and/or Notification may be in place.

4. References:

1. Camzyos® [package insert]. Brisbane, CA: Bristol Myers Squibb; April 2024.
2. Wasfy JH, Walton SM, Beinfeld M, Nhan E, Sarker J, Whittington MD, Pearson SD, Rind DM. Mavacamten for Hypertrophic Cardiomyopathy: Effectiveness and Value; Final Evidence Report and Meeting Summary. Institute for Clinical and Economic Review, November 16, 2021. https://icer.org/hypertrophic-cardiomyopathy-2021/.

3. Ommen SR, Mital S, Burke MA, et al. 2020 AHA/ACC Guideline for the Diagnosis and Treatment of Patients With Hypertrophic Cardiomyopathy: Executive Summary. Circulation. 2020;142(25):e533-e557.

Program	Prior Authorization/Medical Necessity – Camzyos® (mavacamten)
Change Control	
7/2022	New program.
11/2022	Added examples of non-vasodilating beta blockers with no change to intent of coverage criteria.
8/2023	Annual review. Simplified diagnosis criteria. Updated references.
8/2024	Annual review. Updated references.