Health Alliance™

Pharmacy Drug Policy & Procedure

Policy Name:	**Camzyos (mavacamten)**	**Policy #:**	**3143P**

Purpose of the Policy

The purpose of this policy is to define the criteria for coverage of Camzyos (mavacamten) for the treatment of obstructive hypertrophic cardiomyopathy (oHCM).

Statement of the Policy

Health Alliance Medical Plans will cover Camzyos under the Pharmacy benefit if the following criteria are met.

Criteria

1. Coverage Criteria

1.1 Diagnosis of obstructive hypertrophic cardiomyopathy with the following:
- Documented left ventricle ejection fraction ≥55%, AND
- NYHA (New York Heart Association) class II or III

1.2 Member is age 18 years or older

1.3 Prescribed by or in consultation with a REMS (Risk Evaluation and Mitigation Strategy)-certified cardiologist (heart doctor who is enrolled in a drug safety program for Camzyos)

1.4 Trial, failure, or contraindication to beta blockers and/or nondihydropyridine calcium channel blockers (verapamil or diltiazem)

2. Exclusion Criteria

2.1 Diagnosis of a disease that mimics oHCM such as Fabry disease, amyloidosis, Noonan Syndrome with left ventricular hypertrophy

2.2 Concurrent treatment with disopyramide, ranolazine, or combination of beta blockers and calcium channel blockers

3. Managed Dose Limit

3.1 30 tablets per 30 days

4. Approval Period

4.1 Initial Approval: 12 months

4.2 Subsequent Approvals: 12 months with documentation of symptom improvement

CPT Codes

HCPCS Codes

References

1. Camzyos (mavacamten) [prescribing information]. Princeton, NJ: Bristol-Myers Squibb Company; June 2023.
2. Ommen SR, Mital S, Burke MA, et al. 2020 AHA/ACC Guideline for the Diagnosis and Treatment of Patients With Hypertrophic Cardiomyopathy: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *J Am Coll Cardiol* 2020;Nov 20.
3. Olivotto I, Oreziak A, Barriales-Villa R, et al. Mavacamten for treatment of symptomatic obstructive hypertrophic cardiomyopathy (EXPLORER-HCM): a randomised, double-blind, placebo-controlled, phase 3 trial. Lancet 2020; 396:759.

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DISCLAIMER
This Medical Policy has been developed as a guide for determining medical necessity. The process of medical necessity review also entails review of the most recent literature and physician review. Medical Policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise their medical judgment in providing the most appropriate care. Health Alliance encourages input from providers when developing and implementing medical policies. Benefit determinations are based on applicable contract language in the member's Policy/ Subscription Certificate/ Summary Plan Description. This Medical Policy does not guarantee coverage. There may be a delay between the revision of this policy and the posting on the web. Please contact the Health Alliance Customer Service Department at 1-800-851-3379 for verification of coverage.