Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Camzyos - Non-PDL

Phone: 866-841-7659 **Fax back to: 866-240-3712**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
Member ID Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Phone Number:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this a renewal request? If YES, go to 12. If NO, go to 2.

☐ Yes ☐ No

Q2. Is Camzyos (mavacamten) being prescribed by or in consultation with a cardiologist?

☐ Yes ☐ No

Q3. Is the patient greater than or equal to 18 years of age?

☐ Yes ☐ No

Q4. Are clinical notes attached that document a confirmed diagnosis of symptomatic New York Heart Association (NYHA) class II or class III obstructive hypertrophic cardiomyopathy (oHCM), noting associated symptoms? [for example: NYHA Functional Classification - class / symptoms: Class II - Slight limitation of physical activity. Comfortable at rest. Ordinary physical activity results in fatigue, palpitation, shortness of breath or chest pain AND Class III - Marked limitation of physical activity. Comfortable at rest. Less than ordinary activity causes fatigue, palpitation, shortness of breath or chest pain.]

☐ Yes ☐ No

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Q5. Does a recent echocardiogram assessment show left ventricular ejection fraction (LVEF) greater than or equal (>/=) to 55%?

☐ Yes ☐ No

Q6. Does the patient have a peak left ventricular outflow tract (LVOT) gradient greater than or equal (>/=) to 50 mmHg at rest or with provocation.

☐ Yes ☐ No

Q7. Is there a documented history attached supporting trial and failure, contraindication or intolerance to a non-vasodilating beta blocker (such as metoprolol succinate, nadolol) titrated to effectiveness or maximally tolerated doses.

☐ Yes ☐ No

Q8. Is there a documented history attached supporting trial and failure to at least one of the agent types below OR an intolerance to both agents below OR contraindication to both agents below:

☐ a) Non-dihydropyridine calcium channel blockers (such as verapamil er, diltiazem er)
OR,

☐ Disopyramide

Q9. Have other disorders that cause cardiac hypertrophy been ruled out (such as, cardiac amyloidosis, Fabry disease, Noonan syndrome)?

☐ Yes ☐ No

Q10. Is the drug being prescribed at an FDA-approved dose?

☐ Yes ☐ No

Q11. Will the patient be taking Camzyos (mavacamten) with strong CYP2C19 inhibitors or moderate to strong CYP2C19 inducers or moderate to strong CYP3A4 inducers?

☐ Yes ☐ No

Q12. Is there attached documentation showing clinical benefit from baseline as evidenced by improvement in symptoms associated with New York Heart Association (NYHA) class II or class

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III obstructive hypertrophic cardiomyopathy (oHCM) OR that the NYHA is not worsening from baseline?

☐ Yes ☐ No

Q13. Does the patient have a left ventricular ejection fraction (LVEF) greater than or equal to (>/=) to 50%?

☐ Yes ☐ No

Q14. Is the Camzyos (mavacamten) being prescribed at an FDA-approved dose?

☐ Yes ☐ No

Q15. Additional Information:

_____ _____

Prescriber Signature Date

v2026-06