BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

PHARMACY COVERAGE GUIDELINE

CAMZYOS™ (mavacamten) oral
Generic Equivalent (if available)

This Pharmacy Coverage Guideline (PCG):
- Provides information about the reasons, basis, and information sources we use for coverage decisions
- Is not an opinion that a drug (collectively "Service") is clinically appropriate or inappropriate for a patient
- Is not a substitute for a provider's judgment (Provider and patient are responsible for all decisions about appropriateness of care)
- Is subject to all provisions e.g. (benefit coverage, limits, and exclusions) in the member's benefit plan; and
- Is subject to change as new information becomes available.

Scope
- This PCG applies to Commercial and Marketplace plans
- This PCG does not apply to the Federal Employee Program, Medicare Advantage, Medicaid or members of out-of-state Blue Cross and/or Blue Shield Plans

Instructions & Guidance
- To determine whether a member is eligible for the Service, read the entire PCG.
- This PCG is used for FDA approved indications including, but not limited to, a diagnosis and/or treatment with dosing, frequency, and duration.
- Use of a drug outside the FDA approved guidelines, refer to the appropriate Off-Label Use policy.
- The "Criteria" section outlines the factors and information we use to decide if the Service is medically necessary as defined in the Member's benefit plan.
- The "Description" section describes the Service.
- The "Definition" section defines certain words, terms or items within the policy and may include tables and charts.
- The "Resources" section lists the information and materials we considered in developing this PCG
- **We do not accept patient use of samples as evidence of an initial course of treatment, justification for continuation of therapy, or evidence of adequate trial and failure.**
- Information about medications that require prior authorization is available at www.azblue.com/pharmacy. You must fully complete the request form and provide chart notes, lab workup and any other supporting documentation. The prescribing provider must sign the form. Fax the form to BCBSAZ Pharmacy Management at (602) 864-3126 or email it to Pharmacyprecert@azblue.com.

Criteria:

➢ **Criteria for initial therapy:** Camzyos (mavacamten) and/or generic equivalent (if available) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. Prescriber is a physician specializing in the patient's diagnosis or is in consultation with a Cardiologist
2. Individual is 18 years of age or older
3. Individual has a confirmed diagnosis of symptomatic New York Heart Association (NYHA) Class II–III obstructive hypertrophic cardiomyopathy (HCM)
4. Individual has received and completed **ALL** the following **baseline tests** before initiation of treatment and with continued monitoring of the individual as clinically appropriate:
    a. Echocardiogram shows left ventricular ejection fraction (LVEF) is at least 55%

ORIGINAL EFFECTIVE DATE: 05/19/2022 | ARCHIVE DATE: | LAST REVIEW DATE: 05/16/2024 | LAST CRITERIA REVISION DATE: 05/16/2024

b. Left ventricular outflow tract (LVOT) peak gradient is at least 50 mmHg at rest or with exertion
c. Negative pregnancy test in a woman of childbearing potential

5. **If available**: Individual has failure after adequate trial, contraindication per FDA label, intolerance, or is not a candidate for a generic equivalent [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] (see Definitions section)

6. Individual has documented failure, contraindication per FDA label, intolerance, or is not a candidate for a drug from **EACH** of the following:
   a. One of the following beta-blockers: bisoprolol, carvedilol, or metoprolol
   b. One of the following calcium channel blockers: verapamil or diltiazem
   c. One beta-blocker (as from "a" above) plus disopyramide
   d. Calcium channel blocker (as from "b" above) plus disopyramide

7. There are **NO** FDA-label contraindications such as:
   a. Concurrent use of moderate to strong CYP2C19 inhibitors (see Definitions section)
   b. Concurrent use of moderate to strong CYP2C19 inducers (see Definitions section)
   c. Concurrent use of strong CYP3A4 inhibitors (see Definitions section)
   d. Concurrent use of moderate to strong CYP3A4 inducers (see Definitions section)

8. Individual does not have any of the following:
   a. New York Heart Association (NYHA) Class IV
   b. Amyloidosis
   c. Fabry disease
   d. Noonan syndrome with left ventricular hypertrophy
   e. Severe hepatic impairment (Child-Pugh Class C)
   f. Severe (eGFR: 15 to 30 mL/min/1.73m^2) renal impairment and kidney failure (eGFR: less than 15 mL/min/1.73m^2; including individuals on dialysis)

Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Camzyos (mavacamten) and/or generic equivalent (if available) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met **(samples are not considered for continuation of therapy)**:

1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with a Cardiologist

2. Individual's condition has responded while on therapy with response defined as **THREE** of the following:
   a. A decrease in LVOT gradient of at least 30 mmHg with valsalva maneuvers
   b. Maintains LVEF of at least 50%
   c. Improvement in at least one NYHA class
   d. Improvement of peak oxygen consumption (pVO2) by at least a 1.5 mL/kg/min plus improvement on NYHA class of one
   e. Improvement peak oxygen consumption (pVO2) by at least a 3 mL/kg/min plus no worsening in NYHA class

3. Individual has been adherent with the medication and is enrolled in the CAMZYOS REMS PROGRAM

4. **If available**: Individual has failure after adequate trial, contraindication per FDA label, intolerance, or is not a candidate for a generic equivalent [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] (see Definitions section)

5. Individual has not developed any contraindications or other significant adverse drug effects that may exclude continued use as follows:
    a. Contraindications as listed in the criteria for initial therapy section
    b. Significant adverse effect such as:
        i. LVEF is less than 50%
        ii. Experiencing heart failure symptoms or worsening clinical status

6. Individual does not have any of the following:
    a. New York Heart Association (NYHA) Class IV
    b. Amyloidosis
    c. Fabry disease
    d. Noonan syndrome with left ventricular hypertrophy
    e. Severe hepatic impairment (Child-Pugh Class C)

7. Individual has not had two LVEF of less than 50% determinations while on a dose of 2.5 mg daily

Renewal duration: 12 months

- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

1. **Off-Label Use of a Non-Cancer Medication**

2. **Off-Label Use of a Cancer Medication**

Description:

Camzyos (mavacamten) 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.

Camzyos (mavacamten) is an allosteric and reversible inhibitor selective for cardiac myosin. Camzyos (mavacamten) modulates the number of myosin heads that can enter “on actin” (power-generating) states, thus reducing the probability of force-producing (systolic) and residual (diastolic) cross-bridge formation. Excess myosin actin cross-bridge formation and dysregulation of the super-relaxed state are mechanistic hallmarks of HCM. Camzyos (mavacamten) shifts the overall myosin population towards an energy-sparing, recruitable, super-relaxed state. In HCM patients, myosin inhibition with Camzyos (mavacamten) reduces dynamic LVOT obstruction and improves cardiac filling pressures.

PHARMACY COVERAGE GUIDELINE

CAMZYOS™ (mavacamten) oral
Generic Equivalent (if available)

Definitions:

U.S. Food and Drug Administration (FDA) MedWatch Forms for FDA Safety Reporting
MedWatch Forms for FDA Safety Reporting | FDA

Some examples of Cytochrome P450 Interactions: (Not a complete list)

CYP2C19			
Strong Inducer	Moderate Inducer	Strong Inhibitor	Moderate Inhibitor
rifampin	carbamazepine, dabrafenib, enzalutamide, letermovir, phenytoin derivatives, Saint John's wort, tipranavir/ritonavir	delavirdine, fluconazole, fluvoxamine, ticlopidine	armodafinil, cimetidine, eslicarbazepine, esomeprazole, felbamate, fluoxetine, isoniazid, modafinil, omeprazole, oxcarbazepine, voriconazole
CYP3A4			
Strong Inducer	Moderate Inducer	Strong Inhibitor	Moderate Inhibitor
carbamazepine, phenobarbital, phenytoin derivatives, primidone, rifabutin, rifampin, rifapentine, rufinamide, Saint John's wort	armodafinil, bexarotene, bosentan, dabrafenib, deferasirox, dexamethasone, efavirenz, modafinil, nafcillin, nevirapine, oxcarbazepine	clarithromycin, isoniazid, itraconazole, ketoconazole, nefazodone, nelfinavir, posaconazole, ritonavir, telaprevir, telithromycin, tipranavir/ritonavir, voriconazole	amiodarone, aprepitant, cyclosporine, diltiazem, dronedarone, erythromycin, fluconazole, fluvoxamine, grapefruit juice, isavuconazonium, netupitant, verapamil, zafirlukast

Resources:

Camzyos (mavacamten) product information, revised by Myokardia, Inc. 07-2023. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed on February 22, 2024.

Maron MS. Hypertrophic cardiomyopathy: Clinical manifestations, diagnosis, and evaluation. In: UpToDate, McKenna WJ, Dardas TF (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2024. Topic last updated October 04, 2022. Accessed on February 22, 2024.

Maron MS. Hypertrophic cardiomyopathy: Management of patients with outflow obstruction. In: UpToDate, McKenna WJ, Dardas TF (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2024. Topic last updated September 13, 2023. Accessed on February 22, 2024.

Maron MS. Hypertrophic cardiomyopathy: Management of patients with outflow obstruction. In: UpToDate, McKenna WJ, Dardas TF (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2024. Topic last updated June 23, 2023. Accessed on February 22, 2024.

ClinicalTrials.gov Bethesda (MD): National Library of Medicine (US). Identifier NCT03470545: A Randomized, Double Blind, Placebo Controlled Clinical Study to Evaluate Mavacamten (MYK-461) in Adults With Symptomatic Obstructive Hypertrophic Cardiomyopathy. Available from: http://clinicaltrials.gov. Last update posted October 04, 2021. Last verified May 2020. Accessed February 22, 2024.