Effective Date: 08/01/2026
Reviewed: 05/2026

Cardamyst (etripamil)

POLICY

I. CRITERIA FOR APPROVAL

An authorization of 12 months may be granted when all the following criteria are met:

A. Member is at least 18 years of age
B. Documented diagnosis of atrioventricular nodal-dependent paroxysmal supraventricular tachycardia (PSVT) [e.g. atrioventricular nodal reentrant tachycardia (AVNRT), atrioventricular reentrant tachycardia (AVRT)]
C. Prescribed by or in consultation with a specialist in the management of PSVT (e.g., cardiologist or electrophysiologist)
D. Member has a history of sustained episodes of PSVT (typically greater than 20 minutes) that do not consistently resolve with the use of vagal maneuvers (e.g., Valsalva maneuver, carotid sinus massage)
E. Provider has considered catheter ablation or oral preventative therapies, if appropriate
F. Member does not have a contraindication to Cardamyst (e.g., New York Heart Association (NYHA) Class II to IV heart failure, Wolff-Parkinson-White (WPW), Lown-Ganong-Levine (LGL) syndromes, etc.)
G. Member will not use more than four sprays (140 mg) per 24-hour period

II. CONTINUATION OF THERAPY

An authorization of 12 months may be granted for all members who are tolerating treatment with no severe adverse drug reactions and have documented positive clinical response (e.g., successful conversion to sinus rhythm, decrease in PSVT-related ED or provider visits).

III. QUANTITY LIMIT

- One box per fill and four boxes per 365 days

Note: one box contains two devices, each with two sprays/one 70 mg dose

IV. COVERAGE DURATION

- 12 months

V. REFERENCES

1. Cardamyst [package insert]. Charlotte, NC: Milestone Pharmaceuticals USA, Inc.; December 2025. Accessed March 2026.