Effective Date: 9/01/2022
Reviewed: 06/2022, 05/2023, 05/2024, 5/2025
Scope: Medicaid

SPECIALTY GUIDELINE MANAGEMENT

CAMZYOS (mavacamten)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications
Camzyos is 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.

All other indications are considered experimental/investigational and not medically necessary.

II. CRITERIA FOR INITIAL APPROVAL

Symptomatic obstructive hypertrophic cardiomyopathy (oHCM)
Authorization of 6 months may be granted for treatment of oHCM when all of the following criteria are met:

1. This medication must be prescribed by a cardiologist enrolled in the CAMZYOS REMS PROGRAM
2. The member is at least 18 years of age
3. The member's weight is at least 45 kg
4. Documentation that the member has one of the following:
    i. Left ventricular wall thickness greater than or equal to 15 mm anywhere in the left ventricle
    ii. Left ventricular wall thickness greater than or equal to 13mm anywhere in the left ventricle in members with familial hypertrophic cardiomyopathy or a positive genetic test (e.g., MYH7, MYBPC3, TNNI3, TNNT2, TPM1, MYL2, MYL3, ACTC1 gene variants)
5. Documentation that the member's functional status is NYHA Class II or III
6. Documentation that the member has a documented left ventricular ejection fraction (LVEF)≥55% and baseline Valsalva left ventricular outflow tract (LVOT) peak gradient ≥ 50mm Hg.
7. Documentation that the member has experienced an inadequate treatment response, intolerance, or contraindication to beta blockers (e.g. metoprolol, propranolol, atenolol)
8. Documentation that the member has experienced an inadequate treatment response, intolerance, or contraindication to a nondihydropyridine calcium channel blocker (e.g. verapamil, diltiazem)
9. Documentation that the member has experienced an inadequate treatment response, intolerance, or contraindication to disopyramide
10. Documentation that the member is not currently treated or planning to be treated with disopyramide, ranolazine, or dual therapy with a beta blocker and calcium channel blocker
11. Documentation that the member is not currently diagnosed with a disorder that causes cardiac hypertrophy that mimics oHCM, such as Fabry disease, amyloidosis, or Noonan syndrome with LV hypertrophy

III. CONTINUATION OF THERAPY

Authorization of 6 months may be granted for continued treatment in members requesting continuation of therapy when the member is experiencing benefit from therapy documented by both of the following:

1. The member has achieved or maintained a positive clinical response to therapy (increase in pVO2, NYHA class reduction).
2. Member has a LVEF ≥50%

IV. QUANTITY LIMIT

Camzyos 2.5mg, 5mg, 10mg, and 15mg capsules have a quantity limit of 1 capsule per day.

V. REFERENCES

1. Camzyos [package insert]. Brisbane, CA: Bristol Myers Squibb; April 2025.
2. Ommen, SR, Mital S, Burke MA, et al. 2020 AHA/ACC Guideline for the Diagnosis and Treatment of Patients With Hypertrophic Cardiomyopathy. Circulation. 2020; 142:e558–e631.