ALBERTA BLUE CROSS®

MAVACAMTEN
SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

Please complete all required sections to allow your request to be processed.

PATIENT INFORMATION				**COVERAGE TYPE**
LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other ______
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION	
PRESCRIBER LAST NAME / FIRST NAME / INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
STREET ADDRESS	☐ CPSA ☐ CARNA ☐ ACP ☐ ACO ☐ ADA+C ☐ Other — REGISTRATION NUMBER
CITY, PROVINCE	PHONE / FAX
POSTAL CODE	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Coverage Criteria of Mavacamten (e.g. Camzyos)

Special authorization coverage may be provided for adult patients (18 years of age or older) with symptomatic obstructive hypertrophic cardiomyopathy (oHCM) of New York Heart Association (NYHA) class II to III who meet all of the following criteria:
-Patients must have documented left ventricular ejection fraction (LVEF) >/= 55% at rest determined by echocardiography.
-Patients must have left ventricular (LV) wall thickness >/= 15 mm (or >/= 13 mm with a family history of hypertrophic cardiomyopathy).
-Patients must have left ventricular outflow tract (LVOT) peak gradient >/= 50 mm Hg at rest, after Valsalva maneuver, or post exercise, as confirmed by echocardiography.
-Patients must be receiving beta-blocker or calcium channel blocker therapy and experience clinical deterioration in symptoms or echocardiography while receiving either of these treatments.
For coverage, the drug must be initiated in consultation with a Specialist in Cardiology.
-Initial coverage may be approved for up to 5 mg daily for 12 weeks.
For renewal of coverage, the physician must document that patients must NOT have:
-a LVEF </= 30%, NOR received septal reduction therapy.
Continued coverage may be approved for up to 15 mg daily for a period of 12 months.

Please provide the following information for ALL requests

Diagnosis	**Dosage and Frequency**
☐ Obstructive hypertrophic cardiomyopathy (oHCM) ☐ Other, specify ______	

Please provide the following information for INITIAL requests for treatment-naive and treatment-experienced patients

a) Left ventricular ejection fraction **(LVEF)** (%) prior to initiation of mavacamten ______

b) New York Heart Association **(NYHA)** class prior to initiation of mavacamten ______

c) Indicate which of the following apply to this patient at treatment initiation **(check yes or no for i-iii)**

i) Has left ventricular wall thickness greater than or equal to 15 mm (or greater than or equal to 13 mm with a family history of HCM)	☐ Yes	☐ No
ii) Has left ventricular outflow tract (LVOT) peak gradient greater than or equal to 50 mm Hg at rest, after Valsalva maneuver, or post exercise, as confirmed by echocardiography	☐ Yes	☐ No
iii) Is receiving beta-blocker or calcium channel blocker therapy and experienced clinical deterioration in symptoms or echocardiography while receiving either of these treatments	☐ Yes	☐ No

d) For patients already on mavacamten, provide the treatment start date (YYYY-MM-DD) ______

Please provide the following information for RENEWAL requests and INITIAL requests for treatment-experienced patients

e) Is the patient's **current LVEF** greater than 30%? ☐ Yes ☐ No

f) Has the patient received **septal reduction therapy** since initiation of mavacamten? ☐ Yes ☐ No

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX 780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

The information collected by this form is collected pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purpose of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.
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