

Clinical Policy: Mavacamten (Camzyos)

Reference Number: ERX.NPA.162

Effective Date: 04.28.22

Last Review Date: 08.22

Line of Business: Commercial, Medicaid

[Revision Log](#)

See **Important Reminder** at the end of this policy for important regulatory and legal information.

Description

Mavacamten (Camzyos™) is a cardiac myosin inhibitor.

FDA Approved Indication(s)

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.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

Health plan approved formularies should be reviewed for all coverage determinations. Requirements to use preferred alternative agents apply only when such requirements align with the health plan approved formulary.

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ that Camzyos is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Obstructive Hypertrophic Cardiomyopathy (must meet all):

1. Diagnosis of obstructive HCM;
2. Member exhibits NYHA Class II to III symptoms, including but not limited to: effort-related dyspnea or chest pain, or syncope or near syncope attributed to left ventricular outflow tract obstruction;
3. Prescribed by or in consultation with a cardiologist;
4. Age \geq 18 years;
5. Member has left ventricular hypertrophy with maximal left ventricular wall thickness of \geq 15 mm or \geq 13 mm if member has familial hypertrophic cardiomyopathy;
6. Member has a left ventricular ejection fraction (LVEF) \geq 55%;
7. Member has a peak left ventricular outflow tract (LVOT) gradient \geq 50 mmHg at rest or with provocation;
8. Failure of all of the following at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, and c):
 - a. Non-vasodilating beta-blocker (e.g., atenolol, metoprolol, bisoprolol, propranolol);
 - b. Non-dihydropyridine calcium channel blocker (e.g., verapamil, diltiazem);
 - c. Disopyramide;
9. Dose does not exceed 15 mg per day.

Approval duration: 6 months

B. Other diagnoses/indications

1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Obstructive Hypertrophic Cardiomyopathy (must meet all):

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions or member has previously met initial approval criteria;

2. Member is responding positively to therapy as evidenced by improvement in obstructive HCM symptoms;
3. Member has not undergone a septal reduction procedure within the last 6 months;
4. If request is for a dose increase, new dose does not exceed 15 mg per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or

2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:

- A.** Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off-label use policy – ERX.PA.01 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

HCM: hypertrophic cardiomyopathy

LVEF: left ventricular ejection fraction

LVOT: left ventricular outflow tract

NYHA: New York Heart Association

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria.

The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
atenolol	50-100 mg PO QD	200 mg/day
metoprolol	50-100 mg PO QD	400 mg/day
bisoprolol	5-20 mg PO QD	20 mg/day
propranolol	80-320 mg PO QD or divided into 2-4 doses/day	320 mg/day
nadolol	40-80 mg PO QD	240 mg/day
verapamil	80-120 mg PO TID	480 mg/day
diltiazem	Immediate-release (IR): 30 mg PO QID Extended-release (ER): 120-180 mg PO QD	IR: 360 mg/day ER: 360-540 mg/day
disopyramide	200-250 mg PO BID	600 mg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): concomitant use with moderate to strong CYP2C19 inhibitors/inducers, strong CYP3A4 inhibitors, or moderate to strong CYP3A4 inducers
- Boxed warning(s): risk of heart failure due to systolic dysfunction
 - Echocardiogram assessments of LVEF are required prior to and during treatment with Camzyos; initiation of Camzyos in patients with LVEF < 55% is not recommended; interrupt Camzyos if LVEF is < 50% at any visit or if the patient experiences heart failure symptoms or worsening clinical status; because of the risk of heart failure due to systolic dysfunction, Camzyos is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called Camzyos REMS Program

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Obstructive HCM	<u>Initiation:</u> 5 mg PO QD x 4 weeks	15 mg/day

Indication	Dosing Regimen	Maximum Dose
	<p><u>Week 4:</u></p> <ul style="list-style-type: none"> • If Valsalva LVOT gradient is < 20 mmHg, down-titrate to 2.5 mg PO QD • If Valsalva LVOT gradient is ≥ 20 mmHg, maintain 5 mg daily dose <p><u>Week 8:</u></p> <ul style="list-style-type: none"> • If Valsalva LVOT gradient is ≥ 20 mmHg, maintain current dose x 4 weeks and then begin Maintenance therapy at Week 12 • If Valsalva LVOT gradient is < 20 mmHg and previous dose was 2.5 mg daily: withhold drug and return at Week 12 <ul style="list-style-type: none"> ○ At Week 12, restart on 2.5 mg daily dose if LVEF ≥ 50% and recheck clinical status and echocardiogram in 4 weeks ○ Maintain same dose x 8 weeks, consistent with Maintenance dosing, unless LVEF is < 50% • If Valsalva LVOT gradient is < 20 mmHg and previous dose was 5 mg daily: down-titrate to 2.5 mg PO QD x 4 weeks and then begin Maintenance therapy <p><u>Maintenance:</u></p> <ul style="list-style-type: none"> • If LVEF is < 50%: interrupt Camzyos treatment (see instructions for dose interruption below) • If LVEF is 50-55%, regardless of Valsalva LVOT gradient OR LVEF is > 55% and Valsalva LVOT gradient is < 30 mmHg: maintain on the same dose and follow-up 12 weeks later • If LVEF ≥ 55% and Valsalva LVOT gradient ≥ 30 mmHg: Up-titration to next higher daily (mg) dose level (2.5 → 5; 5 → 10; 10 → 15); recheck clinical status and echocardiogram in 4 weeks and maintain the same dose for the next 8 weeks unless LVEF is < 50%; further up-titration is allowed after 12 weeks of treatment on the same dose level <p><u>Dose interruption at any clinic visit if LVEF is < 50%:</u></p> <ul style="list-style-type: none"> • After dose interruption, recheck echocardiogram parameters every 4 weeks until LVEF ≥ 50%; once LVEF ≥ 50%: <ul style="list-style-type: none"> ○ Restart treatment at next lower daily (mg) dose level (5 → 2.5; 10 → 5; 15 → 10; if interrupted at 2.5 mg, restart at 2.5 mg) ○ Recheck clinical status and echocardiogram in 4 weeks and maintain the same dose for the next 8 weeks unless LVEF < 50%; ○ Next follow instructions above for Maintenance dosing • Permanently discontinue Camzyos treatment if LVEF is < 50% twice on 2.5 mg daily dose. 	

VI. Product Availability

Capsules: 2.5 mg, 5 mg, 10 mg, 15 mg

VII. References

1. Camzyos Prescribing Information. Brisbane, CA: Bristol Myers Squibb; April 2022. Available at www.camzyos.com. Accessed May 23, 2022.
2. ClinicalTrials.gov. NCT03470545. Clinical study to evaluate mavacamten (MYK-461) in adults with symptomatic obstructive hypertrophic cardiomyopathy (EXPLORER-HCM). Available at www.clinicaltrials.gov. Accessed November 29, 2021.
3. 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:e558-631. <https://doi.org/10.1161/CIR.0000000000000937>.
4. Olivotto L, Oreziak A, Barriaes-Villa R, et al., Mavacamten for treatment of symptomatic obstructive hypertrophic cardiomyopathy (EXPLORER-HCM): a randomised, double-blind, placebo-controlled, phase 3 trial. *Lancet*. 2020 Sep 12;396:759-69
5. Mavacamten Drug Monograph. Clinical Pharmacology. Accessed May 30, 2022. <https://www.clinicalkey.com/pharmacology/>.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created pre-emptively	11.30.21	02.22
RT1: drug is now FDA approved – criteria updated per FDA labeling: changed “Member exhibits NYHA Class II <u>or</u> III symptoms” to “Member exhibits NYHA Class II <u>to</u> III symptoms”, changed wording of “or after Valsalva maneuver or exercise” to “or with provocation” for alignment with label language; criteria updated per P&T feedback: added requirement for maximal left ventricular wall thickness; references reviewed and updated.	08.23.22	08.22

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information.

This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members.

This policy is the property of Envolve Pharmacy Solutions. Unauthorized copying, use, and distribution of this Policy or any information contained herein is strictly prohibited. By accessing this policy, you agree to be bound by the foregoing terms and conditions, in addition to the Site Use Agreement for Health Plans associated with Envolve Pharmacy Solutions.

©2022 Envolve Pharmacy Solutions. All rights reserved. All materials are exclusively owned by Envolve Pharmacy Solutions and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Envolve Pharmacy Solutions. You may not alter or remove any trademark, copyright or other notice contained herein.