NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

Request for Insured Coverage of Mavacamten (Camzyos)

PATIENT INFORMATION

PATIENT SURNAME	PATIENT GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH

PATIENT ADDRESS

INITIAL REQUEST

For the treatment of patients who meet all of the following criteria:

☐ Symptomatic obstructive hypertrophic cardiomyopathy (oHCM)

☐ New York Heart Association (NYHA) class II to III

☐ Documented left ventricular ejection fraction (LVEF) ≥ 55% at rest determined by echocardiography

☐ Left ventricular (LV) wall thickness ≥ 15 mm (or ≥ 13 mm with a family history of hypertrophic cardiomyopathy)

☐ Left ventricular outflow tract (LVOT) peak gradient ≥ 50 mm Hg at rest, after Valsalva maneuver, or post exercise, as confirmed by echocardiography

☐ Must be receiving beta-blocker or calcium channel blocker therapy and experience clinical deterioration in symptoms or echocardiography while receiving either of these treatments or for patients who have an intolerance or contraindication to treatments, details must be provided.

MEDICATION TRIALS

Medication	Outcome
☐ Beta-blocker: _____ Dose, Duration of therapy: _____	☐ Clinical deterioration in symptoms or echocardiography ☐ Intolerance or contraindication, please specify: _____ _____
☐ Calcium channel blocker: _____ Dose, Duration of therapy: _____	☐ Clinical deterioration in symptoms or echocardiography ☐ Intolerance or contraindication, please specify: _____ _____

RENEWAL REQUEST

Please advise if the patient has any of the following:

☐ Yes ☐ No A LVEF ≤ 30%

☐ Yes ☐ No Received septal reduction therapy

PRESCRIBER NAME & ADDRESS:

_____ **LICENCE #**

_____ **PRESCRIBER SIGNATURE**

_____ **DATE**

If you need assistance, please contact the Pharmacare Office at (902) 496-7001 or 1-800-305-5026

Please Return Form To: Nova Scotia Pharmacare Programs
P.O. Box 500, Halifax, NS B3J 2S1
Fax: (902) 496-4440