MASSACHUSETTS

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Pharmacy Medical Policy

Heart Failure and Hypertrophic Cardiomyopathy (HCM) Policy

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Policy Number: 063

BCBSA Reference Number: None

Related Policies

- Quality Care Dosing guidelines apply to the following medications and can be found in Medical Policy #621A

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Note: All requests for outpatient retail pharmacy for indications listed and not listed on the medical policy guidelines may be submitted to BCBSMA Clinical Pharmacy Operations by completing the Prior Authorization Form on the last page of this document. Physicians may also call BCBSMA Pharmacy Operations department at (800)366-7778 to request a prior authorization/formulary exception verbally. Patients must have pharmacy benefits under their subscriber certificates.
Please refer to the chart below for the formulary and step status of the medications affected by this policy.

Drug	Formulary Information Standard Formulary Status
STEP 1	
• Beta-Blocker	Covered
• ACE Inhibitor	
• ARB	
STEP 2	
• **Entresto** ® (sacubitril and valsartan)	Prior use of one (1) Step 1 Required
• **Farxiga** ® (dapagliflozin)	Prior use of one (1) Step 1 Required

• **Jardiance** ® (empagliflozin)	Prior use of one (1) Step 1 Required
• **Verquvo** ™(vericiguat)	Prior use of one (1) Step 1 Required

Standard Formulary	
Drug	**Formulary Status**
Camzyos ™	PA Required

Step Criteria:

*Non formulary medications are covered when a formulary exception request is submitted to BCBSMA Pharmacy Operations and step criteria below are met.

We may cover the medications listed in the chart above for new starts*# in the following stepped approach.
*#New start is defined as no previous paid claim for the requested medication within the past 130 days.

Step 1: Step 1 medications will be covered without prior authorization.

Step 2: Step 2 medications will be covered when **one** of the following criteria is met:
- There must be evidence of a BCBSMA paid claim by the patient of a step 1 drug within the previous 130 days or previous treatment.

OR
- There must be evidence of a BCBSMA paid claim by the patient of the step 2 drug within the previous 130 days or previous treatment.

NOTE: If a Provider submits a request and BCBSMA issues an approval for a step medication, the authorization will be granted for up to two (2) years. If the Member has claims history verifying a fill of a formulary step 1 or formulary step 2 medication within the past 130 days, and no break in coverage, then formulary step 2 medications will continue to pay at point of sale. If the Member has claims history verifying a fill of a formulary step 2 or formulary step 3 medication within the past 130 days, and no break in coverage, then formulary step 3 medications will continue to pay at point of sale. Non-formulary (not covered) medications within a step policy will not have any automation and a paper, electronic or phone call is required.

**Requests based exclusively on the use of samples will not meet coverage criteria for exception. Additional clinical information demonstrating medical necessity of the desired medication must be submitted by the requesting prescriber for review.

For non-formulary/non-covered medications, requests must meet criteria above and the member must have had a previous treatment failure with or a contraindication to two covered formulary alternatives when available.

Prior Authorization Criteria:

We may cover Camzyos ™ **(**mavacamten**)** for obstructive hypertrophic cardiomyopathy (oHCM) in adult (18 years and older) patients when all of the following criteria are met:

- Diagnosed with oHCM consistent with current ACC/AHA and ESC guidelines (unexplained LV hypertrophy with maximal LV wall thickness of ≥15 mm OR ≥13 mm with family history of HCM; LVOT gradient ≥50 mm Hg)

AND

- Documented LVEF ≥55%

AND

NYHA class II or III

AND

- Member has had prior therapy with or a contraindication or intolerance to beta blockers (e.g. metoprolol, propranolol, atenolol) and/or calcium channel blockers (e.g. verapamil, diltiazem)

AND

- The drug is prescribed by a board-certified or board eligible Cardiologist

We do not cover the medications listed above for other conditions not listed above.

CPT Codes / HCPCS Codes / ICD-9 Codes

The following codes are included below for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

CPT Codes

There is no specific CPT code for this service.

Individual Consideration

All our medical policies are written for the majority of people with a given condition. Each policy is based on medical science. For many of our medical policies, each individual's unique clinical circumstances may be considered in light of current scientific literature. Physicians may send relevant clinical information for individual patients for consideration to:

Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043
Tel: 1-800-366-7778
Fax: 1-800-583-6289

Prior Authorization Information

Outpatient

For services described in this policy, see below for products where prior authorization **IS REQUIRED** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is **required**.
Commercial PPO and Indemnity	Prior authorization is **required**.

Policy History

Date	Action
8/2022	Updated to include Camzyos ™ and updated Policy Name.
7/2022	Clarified Step requirements.
10/2021	Updated to add Farxiga and Jardiance to the policy.
4/2021	Updated to add Verquvo to the policy at step 2 and changed Policy name to Heart Failure Step Therapy.
1/1/2020	Implement new Step therapy policy

References

1. Entresto ® [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation: 11/2018.
2. Verquvo ™[package insert]. Whitehouse Station, NJ: MERCK & CO., INC.: 1/2021.
3. Farxiga ® [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP: 5/2021.
4. Jardiance ® [package insert]. Ridgefield, CT: Boehringer Ingelheim Pharmaceuticals, Inc.: 8/2021.
5. Camzyos ™[package insert]. Brisbane, CA: Myokardia, Inc.: 4/2022.

To request prior authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below:

http://www.bluecrossma.org/medical-policies/sites/g/files/csphws2091/files/acquiadam-assets/023%20E%20Form%20medication%20prior%20auth%20instruction%20prn.pdf