

<<Date>>

<<Health Plan Name>>

ATTN: <<Department>>

<<Medical/Pharmacy Director Name>>

<<Health plan address>>

<<City, State Zip>>

Name: <<Patient's Name>>

DOB: <<XX/XX/XXXX>>

Patient Policy ID Number: <<Policy ID #>>

Reference Number: <<Reference #>>

Date(s) of Service: <<XX/XX/XXXX>>

Re: Letter of Medical Necessity for CAMZYOS™ (mavacamten)

Dear <<Medical/Pharmacy Director Name>>,

I am writing on behalf of <<patient's name>> to request coverage for CAMZYOS™ (mavacamten) for the treatment of <<diagnosis>>, *International Classification of Diseases, 10th Revision, Clinical Modification* diagnosis code <<diagnosis code>>. I have made a treatment decision, at this time, to initiate treatment with CAMZYOS. This letter provides the clinical rationale and relevant information about the patient's medical history.

CAMZYOS is a cardiac myosin inhibitor that is approved by the US Food and Drug Administration <<for the treatment of adults and pediatric patients weighing 30 kg or more with symptomatic obstructive hypertrophic cardiomyopathy (HCM) to improve functional capacity and symptoms.>>¹

The patient is <<a/an age>>-year-old <<male/female/other gender identification>> who was diagnosed with <<diagnosis>> on <<date>>. Below is the rationale for prescribing CAMZYOS based on my patient's disease summary.

Summary of Patient's Medical History:

<<Insert overview of the patient's condition>>

[Note: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient's medical condition. It is your responsibility to determine the requirements for each insurance carrier. For example, you may be asked to provide evidence for the diagnosis of obstructive HCM including septal wall thickness, LVOT gradient, LVEF, pVO2 and family history.]

<<You may want to include:>>

- Patient's history and current condition:
 - Symptoms associated with symptomatic obstructive HCM
 - Signs of obstructive HCM observed via echocardiograms
 - Patient's functional status (NYHA Class)
 - Relevant comorbidities
- Previous and/or current treatments for obstructive HCM (such as beta blockers, calcium channel blockers, or disopyramide):

I am requesting this coverage because <<insert summary of professional opinion of the patient's likely prognosis or disease progression without treatment with CAMZYOS>>. Please see attached documents to support my clinical findings.

<<Insert summary statement as to why you believe treatment with CAMZYOS may be medically necessary>>. Please contact me at <<physician's phone number>> or via email at <<physician's email>> should you have questions or need additional information.

Thank you for your time and immediate attention to this request.

Sincerely,

<<Provider name, contact information, and signature>>

Enclosures: <<List and attach additional documents to support your treatment rationale>>

Reference: 1. CAMZYOS [package insert]. Princeton, NJ: Bristol-Myers Squibb Company; 2026.