<<Date>> Name: <<Patient’s Name>>

<<Health Plan Name>> DOB: <<XX/XX/XXXX>>

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

<<Medical/Pharmacy Director Name>> Reference Number: <<Reference #>>

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

<<City, State Zip>>

Re: Letter of Appeal for CAMZYOS™ (mavacamten) Dear <<Medical/Pharmacy Director Name>>,

I am writing on behalf of <<patient’s name>> to request reconsideration of your denial of coverage for CAMZYOS™ (mavacamten) for the treatment of <<diagnosis>>, *International Classification of Diseases, 10th Revision, Clinical Modification* diagnosis code <<diagnosis code>>. Your reason[s] for the denial <<is/are>> <<reason(s)>>.

Based on my experience with treating patients with <<diagnosis>>, ICD-10-CM diagnosis code <<diagnosis

code>>, and the patient’s condition and medical history, I believe treatment with CAMZYOS is appropriate and medically necessary. This letter provides the clinical rationale and relevant information about the patient’s medical history and treatment.

CAMZYOS is a cardiac myosin inhibitor that was approved by the US Food and Drug Administration in April 2022 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.

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.]*

*<<You may want to include:>>*

<<Insert disease summary>>

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

<<Supporting information as requested by the plan in the denial letter>>

This is my <<level of request>> prior authorization appeal. A copy of the <<level of denial>> denial letter is included along with medical notes in response to the denial. Considering the patient’s history and condition, I believe treatment with CAMZYOS is medically necessary for my patient.

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>>

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