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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 3/16/2026
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:** _____
 _____ **NPI#:** _____ **Specialty:** _____
 _____ **Physician Office Telephone:** _____

Physician Office Address: _____

Drug Name (specify drug) _____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1. What is the patient's diagnosis?
 - Obstructive hypertrophic cardiomyopathy (If checked, go to 2)
 - Other, please specify: (If checked, no further questions)
 - _____

2. Is the requested drug prescribed by or in consultation with a cardiologist? **Y** **N**

3. Is this request for continuation of therapy with the requested drug? **Y** **N**

4. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
 - Yes (If checked, go to 5)
 - No (If checked, go to 14)
 - Unknown (If checked, go to 5)

5. Does the patient have left ventricular wall thickness of greater than or equal to 15 millimeters (mm) anywhere in the left ventricle? ACTION REQUIRED: If Yes, please attach imaging reports, chart notes, or medical record documentation supporting left ventricular wall thickness. ACTION REQUIRED: Submit supporting documentation **Y** **N**

6. Does the patient have a left ventricular wall thickness greater than or equal to 13 millimeters (mm) anywhere in the left ventricle? ACTION REQUIRED: If Yes, please attach imaging reports, chart notes, or medical record documentation supporting left ventricular wall thickness. ACTION REQUIRED: Submit supporting documentation **Y** **N**

7. Does the patient have familial hypertrophic cardiomyopathy or a positive genetic test (e.g., MYH7, MYBPC3, TNNI3, TNNT2, TPM1, MYL2, MYL3, ACTC1 gene variants)? ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of familial hypertrophic cardiomyopathy or a positive genetic test (e.g., MYH7, MYBPC3, TNNI3, TNNT2, TPM1, MYL2, MYL3, ACTC1 gene variants). ACTION REQUIRED: Submit supporting documentation **Y** **N**

8. Does the patient have New York Heart Association (NYHA) functional class II or class III symptoms? **Y** **N**

9. Does the patient have a baseline left ventricular ejection fraction (LVEF) greater than or equal to 55%? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting baseline LVEF is greater than or equal to 55%.
ACTION REQUIRED: Submit supporting documentation Y N
10. Does the patient have a baseline resting left ventricular outflow tract (LVOT) gradient greater than or equal to 30 mmHg? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting baseline resting left ventricular outflow tract (LVOT) gradient greater than or equal to 30 mmHg.
ACTION REQUIRED: Submit supporting documentation Y N
11. Does the patient have a baseline Valsalva left ventricular outflow tract (LVOT) peak gradient greater than or equal to 50 mmHg? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting baseline Valsalva left ventricular outflow tract (LVOT) peak gradient greater than or equal to 50 mmHg.
ACTION REQUIRED: Submit supporting documentation Y N
12. Has the patient experienced an inadequate response to a beta-adrenergic antagonist (e.g., atenolol, metoprolol) or non-dihydropyridine calcium channel blocker (e.g., diltiazem, verapamil) at maximally tolerated dose? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
ACTION REQUIRED: Submit supporting documentation Y N
13. Does the patient have an intolerance or contraindication to both a beta-adrenergic antagonist (e.g., atenolol, metoprolol) and a non-dihydropyridine calcium channel blocker (e.g., diltiazem, verapamil)? ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.
ACTION REQUIRED: Submit supporting documentation Y N
14. Has the patient achieved or maintained a positive clinical response to therapy (e.g., increase in mixed venous oxygen partial pressure [pVO₂], New York Heart Association [NYHA] class reduction)? ACTION REQUIRED: If Yes, please attach chart notes or medical documentation supporting a positive clinical response to therapy.
ACTION REQUIRED: Submit supporting documentation Y N
15. Does the patient have a left ventricular ejection fraction (LVEF) greater than or equal to 50%? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting LVEF greater than or equal to 50%.
ACTION REQUIRED: Submit supporting documentation Y N
16. Is the patient currently receiving treatment with rifampin? Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.