# PRIOR AUTHORIZATION POLICY

**POLICY:** Cardiology – Cardamyst Prior Authorization Policy
- Cardamyst™ (etripamil nasal spray – Milestone)

**REVIEW DATE:** 12/30/2025; selected revision 01/07/2026

***INSTRUCTIONS FOR USE***

*THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.*

## CIGNA NATIONAL FORMULARY COVERAGE:

### OVERVIEW

Cardamyst, a calcium channel blocker (CCB), is indicated for **the conversion of acute symptomatic paroxysmal supraventricular tachycardia (PSVT) to sinus rhythm in adults**.[1]

### Clinical Efficacy

The efficacy of Cardamyst was established in the Phase III, randomized, placebo-controlled, multicenter study (RAPID).[1,2] Eligible patients were ≥ 18 years of age with a history of PSVT with sustained, symptomatic episodes (≥ 20 minutes) as documented by electrocardiogram (ECG). Patients with an episode of perceived PSVT were to self-administer Cardamyst or placebo in a medically unsupervised setting and self-administer a second dose if symptoms persisted at 10 minutes after the first dose. If symptoms did not resolve within 30 minutes, patients sought emergent care. The ECG recording was continued for 5 hours regardless of resolution of systems. The primary efficacy endpoint was time to adjudicated

conversion of confirmed atrioventricular-nodal-dependent PSVT to sinus rhythm for at least 30 seconds within 30 minutes of Cardamyst administration. The primary efficacy outcome occurred in 63 (64%) of 99 patients in the Cardamyst group and 26 (31%) of patients in the placebo group (hazard ratio 2.62; 95% confidence interval [CI]: 1.66, 4.15; P < 0.0001). The median time to conversion was 17.2 minutes for Cardamyst (95% CI: 13.4, 26.5) vs. 53.5 minutes for placebo (95% CI: 38.7, 87.3).

## Guidelines

Cardamyst is not yet addressed in guidelines. The 2015 American College of Cardiology/American Heart Association/Heart Rhythm Society guideline for the management of adult patients with supraventricular tachycardia (SVT) divides treatment into acute treatment and ongoing management. Vagal maneuvers and/or intravenous (IV) administration of adenosine is recommended first-line; if this is not effective or is not feasible, next steps depend on the patient's hemodynamic status. If the patient is not hemodynamically stable, synchronized cardioversion is recommended (Class I recommendation); alternatively, hemodynamically stable patients can have IV beta blockers, IV diltiazem, or IV verapamil (Class IIa recommendation). For ongoing management, electrophysiological studies are recommended with consideration of ablation. If a patient cannot or is unwilling to undergo ablation, they are referred for medical therapy, which includes beta-blockers, diltiazem, verapamil, or anti-arrhythmics (e.g., flecainide, propafenone, amiodarone). Individual patient management depends on the presence of structural or ischemic heart disease, contraindications, and other relevant patient factors. The 2019 European Society Guidelines for the management of patients with SVT make similar recommendations. Of note, European SVT guidelines do not suggest the acute use of oral medications for terminating PSVT, and US guidelines reserve this approach for select patients with infrequent, well-tolerated, AV-nodal reentrant tachycardia.

## POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Cardamyst. All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Cardamyst as well as the monitoring required for adverse events and long-term efficacy, approval requires Cardamyst to be prescribed by or in consultation with a physician who specializes in the condition being treated.

**Cardamyst™ (etripamil nasal spray – Milestone)**
**is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):**

## FDA-Approved Indication

1. **Paroxysmal Supraventricular Tachycardia.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   **A)** Patient is ≥ 18 years of age; AND
   **B)** Patient has a history of sustained (≥ 20 minutes) paroxysmal supraventricular tachycardia; AND
   **C)** The medication is prescribed by or in consultation with a cardiologist or electrophysiologist.

## CONDITIONS NOT COVERED

**Cardamyst™ (etripamil nasal spray – Milestone)**
**is(are) considered not medically necessary for ANY other use(s). Criteria will be updated as new published data are available.**

## REFERENCES


1. Cardamyst™ nasal spray [prescribing information]. Charlotte, NC: Milestone; December 2025.
2. Stambler BS, Camm AJ, Alings M, et al. Self-administered intranasal etripamil using a symptom-prompted, repeat-dose regimen for atrioventricular-nodal-dependent supraventricular tachycardia (RAPID): a multicenter, randomized trial. *Lancet*. 2023;402:118-128.
3. Page RL, Joglar JA, Caldwell MA, et al. 2015 ACC/AHA/HRS guideline for the management of adult patients with supraventricular tachycardia: a report of the American College of Cardiology/American Heart Association task force on clinical practice guidelines and the heart rhythm society. *Circulation*. 2015;133(14):e506-574.
4. Brugada J, Katritsis DG, Arbelo E, et al. 2019 ESC guidelines for the management of patients with supraventricular tachycardia. *European Heart Journal*. 2020;41:655-720.


## HISTORY

| Type of Revision | Summary of Changes | Review Date |
|---|---|---|
| New Policy | -- | 12/30/2025 |
| Selected Revision | **Paroxysmal Supraventricular Tachycardia**. The requirement for history of paroxysmal supraventricular tachycardia was clarified to include that this is sustained (≥ 20 minutes). | 01/07/2026 |