

## Cardamyst™ (etripamil)

**Policy # 00969**

Original Effective Date: 06/01/2026

Current Effective Date: 06/01/2026

*Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the “Company”), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.*

*Investigational or experimental services are not covered. This includes any drug, device, procedure, or service provided under the investigational arm of a clinical trial or clinical study. These services are excluded from coverage under benefits.*

## When Services May Be Eligible for Coverage

*Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:*

- *Benefits are available in the member’s contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider Cardamyst™<sup>‡</sup> (etripamil) to be **eligible for coverage\*\*** when the patient selection criteria are met.

### Patient Selection Criteria

Coverage eligibility for Cardamyst (etripamil) will be considered when the following criteria are met:

#### **Initial**

- Patient is 18 years of age or older; AND
- Patient has a diagnosis of paroxysmal supraventricular tachycardia (PSVT); AND
- Patient has a history of sustained (greater than or equal to 20 minutes) PSVT; AND  
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary\*\* if not met.)*
- Patient has had at least one emergency department (ED)/urgent care or provider visit for treatment of an acute episode of PSVT in the prior 12 months despite instruction in vagal maneuvers; AND  
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary\*\* if not met.)*
- The requested medication will be used for the conversion of acute symptomatic episodes of PSVT; AND
- Patient does not have atrial arrhythmias that do not involve the AV node (e.g., atrial fibrillation, atrial flutter) as the treated rhythm; AND  
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary\*\* if not met.)*

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- Patient has tried and failed (e.g., intolerance or inadequate response) an as-needed oral non-dihydropyridine calcium channel blocker (e.g., verapamil or diltiazem) or a beta-blocker used for episode termination unless there is clinical evidence or patient history that suggests these measures will be ineffective or cause an adverse reaction to the patient; AND  
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary\*\* if not met.)*
- Patient does NOT have any of the following:
  - New York Heart Association (NYHA) Class II to IV heart failure; OR
  - Wolff-Parkinson-White (WPW), Lown-Ganong-Levine (LGL) syndromes, or manifest pre-excitation (delta wave) on a 12-lead ECG; OR
  - Sick sinus syndrome without a permanent pacemaker; OR
  - Second degree atrioventricular (AV) Mobitz 2 block or higher degree of AV block.

### Continuation

- Patient has received an initial authorization; AND
- Patient has demonstrated a clinically meaningful beneficial response to Cardamyst therapy as evidenced by the following:
  - Successful conversion to sinus rhythm
  - Decrease in PSVT related ED/urgent care or provider supervised visit since initiation of therapy.

*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary\*\* if not met.)*

## When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of Cardamyst (etripamil) when the patient does not have a history of sustained (greater than or equal to 20 minutes) PSVT to be **not medically necessary.\*\***

Based on review of available data, the Company considers the use of Cardamyst (etripamil) when the patient has not had at least one emergency department (ED)/urgent care or provider visit for treatment of an acute episode of PSVT in the prior 12 months despite instruction in vagal maneuvers to be **not medically necessary.\*\***

Based on review of available data, the Company considers the use of Cardamyst (etripamil) when the patient has atrial arrhythmias that do not involve the AV node (e.g., atrial fibrillation, atrial flutter) as the treated rhythm to be **not medically necessary.\*\***

Based on review of available data, the Company considers the use of Cardamyst (etripamil) when the patient has not tried and failed an as-needed oral non-dihydropyridine calcium channel blocker (e.g., verapamil or diltiazem) or a beta-blocker used for episode termination to be **not medically necessary.\*\***

Based on review of available data, the Company considers the continued use of Cardamyst (etripamil) when the patient has not demonstrated a clinically meaningful beneficial response to Cardamyst therapy to be **not medically necessary.\*\***

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## When Services Are Considered Investigational

*Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.*

Based on review of available data, the Company considers the use of Cardamyst (etripamil) for any indication other than symptomatic PSVT to be **investigational**.\*

Based on review of available data, the Company considers the use of Cardamyst (etripamil) when the patient selection criteria are not met (EXCEPT those denoted as **not medically necessary**\*\*) to be **investigational**.\*

## Background/Overview

Cardamyst (etripamil nasal spray) is a calcium channel blocker indicated for the conversion of acute symptomatic episodes of paroxysmal supraventricular tachycardia (PSVT) to sinus rhythm in adults. Etripamil acts at the atrioventricular (AV) node by modulating calcium influx, thereby interrupting AV-nodal-dependent re-entry and restoring sinus rhythm. Cardamyst is administered intranasally as a symptom-prompted therapy, with an initial 70 mg dose and an optional second dose if symptoms persist after 10 minutes. With appropriate training, Cardamyst may be self-administered by patients or caregivers outside of a healthcare setting. It is supplied as single-use disposable nasal spray devices and is the first intranasal therapy approved for this indication.

Paroxysmal supraventricular tachycardia (PSVT) is a type of supraventricular tachycardia characterized by sudden onset and termination of rapid, regular heart rhythms originating above the ventricles, most commonly involving the AV node. Episodes are often associated with heart rates exceeding 150 to 200 beats per minute and may occur unpredictably. Common symptoms include palpitations, chest discomfort, shortness of breath, lightheadedness, dizziness, syncope, and significant patient distress. Management of PSVT includes acute termination of arrhythmic episodes and prevention of recurrence. Initial treatment strategies for acute episodes typically involve conservative measures such as vagal maneuvers. If these are unsuccessful, intravenous pharmacologic therapy, including adenosine, beta-blockers, or non-dihydropyridine calcium channel blockers, may be used, often requiring hospitalization. Synchronized cardioversion is reserved for hemodynamically unstable patients. Long-term management focuses on reducing recurrence and improving quality of life, with catheter ablation considered a preferred option for many patients due to its potential curative effect. For patients who are unable or unwilling to undergo ablation, oral antiarrhythmic agents, beta-blockers, or calcium channel blockers may be used on a daily or episodic basis. Current clinical guidelines address established pharmacologic and interventional therapies for PSVT; however, Cardamyst is not yet specifically addressed in published guideline recommendations.

## FDA or Other Governmental Regulatory Approval

### U.S. Food and Drug Administration (FDA)

Cardamyst was approved in 2025 for the conversion of acute symptomatic episodes of paroxysmal supraventricular tachycardia (PSVT) to sinus rhythm in adults.

## **Rationale/Source**

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to regulations, other plan medical policies, and accredited national guidelines.

The efficacy of Cardamyst for the treatment of acute symptomatic paroxysmal supraventricular tachycardia (PSVT) is supported by the RAPID trial, a Phase III, randomized, double-blind, placebo-controlled, multicenter study. RAPID evaluated a symptom-prompted, self-administered intranasal dosing regimen in adults with a documented history of sustained, symptomatic PSVT, with an initial 70 mg dose and an optional repeat dose after 10 minutes if symptoms persisted. The primary endpoint was time to adjudicated conversion of AV-nodal–dependent PSVT to sinus rhythm for at least 30 seconds within 30 minutes. Treatment with Cardamyst resulted in a higher rate of conversion compared with placebo (64% vs. 31%), with a shorter median time to conversion (17.2 minutes vs. 53.5 minutes, respectively). A substantial proportion of patients in both treatment arms were receiving background beta-blocker or calcium channel blocker therapy.

## **References**

1. Cardamyst [package insert]. Milestone Pharmaceuticals USA. Charlotte, North Carolina. Updated December 2025.
2. Cardamyst. Drug Evaluation. Express Scripts. Updated December 2025.

## **Policy History**

Original Effective Date: 06/01/2026

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05/07/2026 Medical Policy Committee review

05/13/2026 Medical Policy Implementation Committee approval. New policy.

Next Scheduled Review Date: 05/2027

\*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

- A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
  1. Consultation with technology evaluation center(s);

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2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
3. Reference to federal regulations.

**\*\*Medically Necessary (or “Medical Necessity”)** - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. In accordance with nationally accepted standards of medical practice;
- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

**NOTICE:** If the Patient’s health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

**NOTICE:** Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

**NOTICE:** Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

**NOTICE:** If an authorization for an ongoing course of treatment has been provided to a member and the member changes from one health plan to another health plan (e.g., a member moves from carrier A to Louisiana Blue), Louisiana Blue may honor the previous health plan’s authorization for the same service under the same type of in-network benefit for a 90-day transition period. Documentation of the authorization for the ongoing course of treatment from the previous health plan must be provided to us by the member or their provider and the services provided for the course of treatment must otherwise be a covered service under the Louisiana Blue health plan. This provision does not apply to medications covered under the plan’s pharmacy benefit.