Clinical Policy: Etripamil (Cardamyst)

Reference Number: CP.PMN.306
Effective Date: 03.01.26
Last Review Date: 02.26
Line of Business: Commercial, HIM, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Etripamil (Cardamyst™) is a calcium channel blocker.

FDA Approved Indication(s)

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

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results, or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Cardamyst is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Paroxysmal Supraventricular Tachycardia (must meet all)**:**

1. Diagnosis of PSVT confirmed by electrocardiogram (ECG);
2. Prescribed by or in consultation with a cardiologist or electrophysiologist;
3. Age ≥ 18 years;
4. Member has a history of sustained, symptomatic episodes of PSVT (i.e., typically lasting approximately 20 minutes or longer, *see Appendix D*);
5. One of the following (a or b):
   a. Member has experienced at least one episode of PSVT that required hospitalization or visit to an emergency department/urgent care within the last 12 months;
   b. Member is currently receiving oral pharmacologic therapy for prevention of PSVT episodes (e.g., diltiazem, verapamil, metoprolol, atenolol, propranolol, nadolol, flecainide, propafenone);
6. If member is currently receiving oral pharmacologic therapy for prevention of PSVT episodes, Cardamyst is prescribed concurrently with ongoing oral pharmacologic therapy for prevention;
7. Provider attestation that catheter ablation has been considered but is not appropriate for the member at this time;
8. At the time of request, member has none of the following contraindications (a – f):
   a. Wolff-Parkinson-White syndrome;
   b. Lown-Ganong-Levine syndrome;
   c. Manifest pre-excitation (delta wave) on a 12-lead ECG;

d. Second degree atrioventricular (AV) Mobitz 2 block or higher degree of AV block;
e. New York Heart Association (NYHA) Class II to IV heart failure;
f. Sick sinus syndrome without a permanent pacemaker;

9. Request does not exceed 4 nasal spray devices per month;
10. Dose does not exceed both of the following (a and b) in a 24-hour period:
    a. 140 mg;
    b. 2 nasal spray devices.

Approval duration: 12 months (up to 4 nasal spray devices per month)

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
    a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
    b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Paroxysmal Supraventricular Tachycardia (must meet all)**:**

1. Member meets one of the following (a or b):
    a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
    b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B)*;
2. Member is responding positively to therapy;
3. If member was previously receiving oral pharmacologic therapy for prevention of PSVT episodes, Cardamyst is prescribed concurrently with ongoing oral pharmacologic therapy for prevention;
4. Request does not exceed 4 nasal spray devices per month;
5. If request is for a dose increase, new dose does not exceed both of the following (a and b) in a 24-hour period:
    a. 140 mg;
    b. 2 nasal spray devices.

Approval duration: 12 months (up to 4 nasal spray devices per month)

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AV: atrioventricular
ECG: electrocardiogram
FDA: Food and Drug Administration
NYHA: New York Heart Association
PSVT: paroxysmal supraventricular tachycardia

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): hypersensitivity; heart failure - NYHA Class II to IV; Wolff-Parkinson-White, Lown-Ganong-Levine syndromes, or manifest pre-excitation (delta wave) on a 12-lead ECG; sick sinus syndrome (except in patients with a permanent pacemaker); second degree AV Mobitz 2 block or higher degree of AV block
- Boxed warning(s): none reported

Appendix D: General Information

- Examples of symptoms associated with PSVT episodes include the following: palpitations, chest discomfort, shortness of breath, lightheadedness, dizziness, anxiety, neck pulsations

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
PSVT	One spray into each nostril for a total initial dose of 70 mg. If symptoms persist after 10 minutes, use the second nasal spray device to administer a second dose of one spray into each nostril (70 mg total).	140 mg in a 24-hour period

VI. Product Availability

Nasal spray: 70 mg

VII. References

1. Cardamyst Prescribing Information. Charlotte, NC: Milestone Pharmaceuticals USA, Inc.; December 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/218571s000lbl.pdf. Accessed January 6, 2026.
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 multicentre, randomised trial. Lancet. 2023 Jul 8; 402(10396): 118-128. doi: 10.1016/S0140-6736(23)00776-6.
3. Page RL, Joglar JA, Caldwell MA, et al. 2015 ACC/AHA/HRS guideline for the management of adult patients with supraventricular tachycardia: Executive summary: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Rhythm Society. Circulation. 2016 Apr 5; 133(14): e471-505. doi: 10.1161/CIR.0000000000000310.
4. Brugada J, Katritsis DG, Arbelo E, et al. The Task Force for the management of patients with supraventricular tachycardia of the European Society of Cardiology (ESC): Developed in collaboration with the Association for European Paediatric and Congenital Cardiology (AEPC). European Heart Journal. 2020 Feb 1; 41(5): 655-720. doi: 10.1093/eurheartj/ehz467

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	01.13.26	02.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.