MEDICAL MUTUAL®

Drug Policy

Policy:	Myqorzo (aficamten)	Annual Review Date: 05/21/2026 Last Revised Date: 05/21/2026

OVERVIEW

Myqorzo, a cardiac myosin inhibitor, is indicated for the **treatment of symptomatic obstructive hypertrophic cardiomyopathy (HCM)** to improve functional capacity and symptoms in adults.[1]

POLICY STATEMENT

This policy involves the use of Myqorzo. Prior authorization is recommended for pharmacy benefit coverage of Myqorzo. Approval is recommended for those who meet the conditions of coverage in the **Criteria and Initial/Extended Approval** for the diagnosis provided. **Conditions Not Recommended for Approval** are listed following the recommended authorization criteria. Requests for uses not listed in this policy will be reviewed for evidence of efficacy and for medical necessity on a case-by-case basis.

Because of the specialized skills required for evaluation and diagnosis of patients treated with Myqorzo as well as the monitoring required for adverse events and long-term efficacy, initial approval requires Myqorzo be prescribed by or in consultation with a physician who specializes in the condition being treated. All approvals for initial therapy are provided for the initial approval duration noted below; if reauthorization is allowed, a response to therapy is required for continuation of therapy unless otherwise noted below.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Myqorzo is recommended in those who meet the following criteria:

1. **Obstructive Hypertrophic Cardiomyopathy.** Approve for the duration noted below if the patient meets ONE of the following (A or B):
   - **A)** Initial Therapy. Approve for 1 year if the patient meets ALL of the following (i, ii, iii, iv, v, vi, and vii):
     - **i.** Patient is ≥ 18 years of age; AND
     - **ii.** Patient meets BOTH of the following (a and b):
       - **a)** Patient has at least one symptom associated with obstructive hypertrophic cardiomyopathy; AND
         Note: Examples of symptoms include shortness of breath, chest pain, lightheadedness, fainting, fatigue, and reduced ability to perform physical exercise.
       - **b)** Patient has New York Heart Association Class II or III symptoms of heart failure; AND
     - **iii.** Patient with left ventricular hypertrophy meets ONE of the following (a or b):
       - **a)** Patient has maximal left ventricular wall thickness ≥ 15 mm; OR
       - **b)** Patient has familial hypertrophic cardiomyopathy with a maximal left ventricular wall thickness ≥ 13 mm; AND

iv. Patient has a peak left ventricular outflow tract gradient ≥ 30 mmHg at rest or ≥ 50 mmHg after provocation (Valsalva maneuver or post exercise); AND

v. Patient has a left ventricular ejection fraction of ≥ 55%; AND

vi. Patient meets ONE of the following (a or b):

a) Patient has tried or is currently receiving at least one beta-blocker or nondihydropyridine calcium channel blocker for at least 3 months; OR

Note: Examples of beta-blockers include metoprolol, atenolol, and bisoprolol. Examples of nondihydropyridine calcium channel blockers include verapamil and diltiazem.

b) According to the prescriber, the patient has a contraindication or intolerance to a beta-blocker or nondihydropyridine calcium channel blocker; AND

Note: Examples of contraindications to beta-blockers include bradycardia, severe hypotension, severe reactive airway disease or active bronchospasms. Examples of intolerances to beta-blockers include symptomatic fatigue or exercise intolerance, symptomatic bradycardia, and hypotension. Examples of contraindications to calcium channel blockers include bradycardia and hypotension. Examples of intolerances to calcium channel blockers include peripheral edema and dizziness or orthostasis.

vii. The medication is prescribed by a cardiologist; OR

B) Patient Currently Receiving Myqorzo. Approve for 1 year if the patient meets ALL of the following (i, ii, iii, iv, and v):

i. Patient has been established on therapy for at least 1 year; AND

Note: A patient who has received < 1 year of therapy or who is restarting therapy is reviewed under criterion A (Initial Therapy).

ii. Patient is ≥ 18 years of age; AND

iii. Patient meets BOTH of the following (a and b):

a) Currently or prior to starting therapy, patient has or has experienced at least one symptom associated with obstructive hypertrophic cardiomyopathy; AND

Note: Examples of symptoms include shortness of breath, chest pain, lightheadedness, fainting, fatigue, and reduced ability to perform physical exercise.

b) Currently or prior to starting therapy, patient is in or was in New York Heart Association Class II or III heart failure; AND

iv. Patient meets ONE of the following (a or b):

a) Patient experienced a beneficial clinical response when assessed by at least one objective measure; OR

Note: Examples include improved peak oxygen consumption/mixed venous oxygen tension; decreases in left ventricular outflow tract gradient; reductions in N-terminal pro-B-type natriuretic peptide levels; decreased high-sensitivity cardiac troponin I levels; reduced ventricular mass index; and/or a reduction in maximum left atrial volume index.

b) Patient experienced stabilization or improvement in at least one symptom related to obstructive hypertrophic cardiomyopathy; AND

Note: Examples of symptoms include shortness of breath, chest pain, lightheadedness, fainting, fatigue, ability to perform physical exercise, and/or favorable changes in the Kansas City Cardiomyopathy Questionnaire-23 (KCCQ-23) Clinical Summary Score (CSS) or Hypertrophic Cardiomyopathy Symptom Questionnaire (HCMSQ) Shortness of Breath domain scores.

v. The medication is prescribed by a cardiologist.

Initial Approval/ Extended Approval.
A) *Initial Approval:* 1 year
B) *Extended Approval:* 1 year

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Myqorzo has not been shown to be effective, or there are limited or preliminary data or potential safety concerns that are not supportive of general approval for the following conditions. (Note: This is not an exhaustive list of Conditions Not Recommended for Approval).

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

Documentation Requirements:
The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational, or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

REFERENCES

1. Myqorzo™ tablets [prescribing information]. South San Francisco, CA: Cytokinetics; December 2025.
2. Braundwald E. Hypertrophic cardiomyopathy. *N Engl J Med.* 2025;393(10):1004-1015.
3. Maron MS, Masri A, Nassif ME, et al. Aficamten for symptomatic obstructive hypertrophic cardiomyopathy. *NEJM*. 2024;390(20):1849-1861.
4. Ommen SR, Ho CY, Asif IM, et al. 2024 ACC/AHA/AMSSM/HRS/PACES/SCMR guideline for the management of hypertrophic cardiomyopathy: a report of the American Heart Association/American College of Cardiology joint committee on clinical practice guidelines. *Circulation.* 2024;149(23):1524-4539.