

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 2394-1
Program	Prior Authorization/Medical Necessity
Medication	Myqorzo™ (aficamten)
P&T Approval Date	2/2026
Effective Date	5/1/2026

1. Background:

Myqorzo (aficamten) is a cardiac myosin inhibitor indicated for the treatment of adults with symptomatic obstructive hypertrophic cardiomyopathy (oHCM) to improve functional capacity and symptoms.

2. Coverage Criteria^a:

<p>A. <u>Initial Authorization</u></p> <p>1. Myqorzo will be approved based on <u>all</u> of the following criteria:</p> <p style="padding-left: 20px;">a. Diagnosis of obstructive hypertrophic cardiomyopathy (HCM)</p> <p style="text-align: center;">-AND-</p> <p style="padding-left: 20px;">b. Heart failure is classified as <u>one</u> of the following:</p> <p style="padding-left: 40px;">(1) New York Heart Association (NYHA) class II heart failure</p> <p style="text-align: center;">-OR-</p> <p style="padding-left: 40px;">(2) New York Heart Association (NYHA) class III heart failure</p> <p style="text-align: center;">-AND-</p> <p style="padding-left: 20px;">c. <u>Both</u> of the following were measured prior to Myqorzo therapy:</p> <p style="padding-left: 40px;">(1) Patient had a left ventricular ejection fraction of greater than or equal to 55%</p> <p style="text-align: center;">-AND-</p> <p style="padding-left: 40px;">(2) Patient had a Valsalva left ventricular outflow tract (LVOT) peak gradient greater than or equal to 50 mmHg at rest or with provocation</p> <p style="text-align: center;">-AND-</p> <p style="padding-left: 20px;">d. History of inadequate response, intolerance, failure, or contraindication to one of the following at a maximally tolerated dose:</p>

- (1) Non-vasodilating beta blocker (e.g., atenolol, bisoprolol, metoprolol, nadolol, propranolol)
- (2) Nondihydropyridine calcium channel blocker (i.e., diltiazem, verapamil)

-AND-

- e. Not used in combination with another cardiac myosin inhibitor [i.e., Camzyos (mavacamten)]

-AND-

- f. Prescribed by or in consultation with a cardiologist

Authorization will be issued for 12 months

B. Reauthorization

1. **Myqorzo** will be approved based on **all** of the following criteria:

- a. Documentation of positive clinical response to therapy (e.g., reduction in NYHA class, no worsening in NYHA class)

-AND-

- b. Patient has a left ventricular ejection fraction of greater than or equal to 50%

-AND-

- c. Not used in combination with another cardiac myosin inhibitor [i.e., Camzyos (mavacamten)]

-AND-

- d. Prescribed by or in consultation with a cardiologist

Authorization will be issued for 12 months

^a State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits and/or Medical Necessity may be in place.

4. References:

1. Myqorzo™ [package insert]. South San Francisco, CA: Cytokinetics Incorporated; December 2025.
2. Maron MS, Masri A, Nassif ME, et al. Aficamten for Symptomatic Obstructive Hypertrophic Cardiomyopathy. *N Engl J Med*. 2024;390(20):1849-1861. doi:10.1056/NEJMoa2401424
3. Ommen SR, Ho CY, Asif IM, et al. 2024 AHA/ACC/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 [published correction appears in *Circulation*. 2024 Aug 20;150(8):e198. doi: 10.1161/CIR.0000000000001277.]. *Circulation*. 2024;149(23):e1239-e1311. doi:10.1161/CIR.0000000000001250

Program	Prior Authorization/Medical Necessity - Myqorzo™ (aficamten)
Change Control	
2/2026	New program.