UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 1511-1
Program	Prior Authorization/Notification
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]:

A. Initial Authorization

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

   a. Diagnosis of obstructive hypertrophic cardiomyopathy (HCM)

   -AND-

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

   Authorization will be issued for 12 months.

B. Reauthorization

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

   a. Documentation of positive clinical response to **Myqorzo** therapy

   -AND-

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

   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.

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