UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

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| Program Number | 2026 P 2394-2 |
| Program | Prior Authorization/Medical Necessity |
| Medication | Myqorzo™ (aficamten) |
| P&T Approval Date | 2/2026, 5/2026 |
| Effective Date | 8/1/2026 |

**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 **all** of the following criteria:

   a. Diagnosis of obstructive hypertrophic cardiomyopathy (HCM)

   **-AND-**

   b. Heart failure is classified as **one** of the following:

      (1) New York Heart Association (NYHA) class II heart failure

      **-OR-**

      (2) New York Heart Association (NYHA) class III heart failure

      **-AND-**

   c. **Both** of the following were measured prior to Myqorzo therapy:

      (1) Patient had a left ventricular ejection fraction of greater than or equal to 55%

      **-AND-**

      (2) Patient had a left ventricular outflow tract (LVOT) peak gradient greater than or equal to 50 mmHg at rest or with provocation (i.e., Valsalva or exercise)

      **-AND-**

   d. History of inadequate response, intolerance, failure, or contraindication to one of the following at a maximally tolerated dose:

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(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. <u>Reauthorization</u>**

1. **Myqorzo** will be approved based on **<u>all</u>** 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.

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**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. |
| 5/2026 | Clarified LVOT criteria prior to starting therapy without changing clinical criteria. |

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