MEDICATION POLICY:
Cardiac Myosin Inhibitors

Applicable Drugs: Camzyos (mavacamten), Myqorzo (aficamten)

Preferred: N/A

Non-preferred: N/A

Date of Origin: 8/29/2022

Date Last Reviewed / Revised: 9/28/2026

Prior Authorization Criteria

(May be considered medically necessary when criteria I through V are met)

I. Documented diagnosis of obstructive hypertrophic cardiomyopathy (HCM) AND must meet the following criteria:
   A. Documented left ventricular hypertrophy meeting one of the following criteria (1 or 2):
      1. Maximal left ventricular wall thickness greater than or equal to 15 mm.
      2. Familial hypertrophic cardiomyopathy with maximal left ventricular wall thickness greater than or equal to 13 mm.
   B. Documented New York Heart Association (NYHA) class II or III heart failure.
   C. Documented left ventricular ejection fraction (LVEF) greater than or equal to 55%.
   D. Documented peak left ventricular outflow tract (LVOT) gradient greater than or equal to 50 mmHg at rest or with provocation (ie, Valsalva or post exercise).
   E. Documented treatment failure, intolerance, or contraindication to at least one agent from both of the following drug classes:
      1. Non-vasodilating beta blocker (eg, atenolol, bisoprolol, metoprolol, nadolol, propranolol) at maximally titrated dose.
      2. Non-dihydropyridine calcium channel blocker (eg, diltiazem or verapamil) at maximally titrated dose.

II. Minimum age requirement: 18 years old.

III. Must be prescribed by or in consultation with a cardiologist.

IV. Request is for a medication with the appropriate FDA labeling, or its use is supported by current clinical practice guidelines.

V. Refer to plan document for the list of preferred products. If requested agent is not listed as a preferred product, must have a documented failure, intolerance, or contraindication to the preferred product(s).

Exclusion Criteria

- Diagnosis of other conditions that cause cardiac hypertrophy that mimics HCM, such as Fabry disease, amyloidosis, or Noonan syndrome with left ventricular hypertrophy.

- Concurrent use of Camzyos and Myqorzo.

OTHER CRITERIA

- Camzyos and Myqorzo are available through their respective REMS programs.

QUANTITY / DAYS SUPPLY RESTRICTIONS

- Camzyos: 30 capsules per 30 days
- Myqorzo: 30 tablets per 30 days

APPROVAL LENGTH

- **Authorization:** 12 months.
- **Re-Authorization:** 12 months. An updated letter of medical necessity or progress notes showing current medical necessity criteria are met, that the medication is effective (eg, improvement or stabilization of NYHA class), and LVEF remains greater than or equal to 50%.

APPENDIX

N/A

REFERENCES

1. Camzyos. Prescribing information. Bristol Myers Squibb; 2024. Accessed August 5, 2026. https://packageinserts.bms.com/pi/pi_camzyos.pdf
2. Myqorzo. Prescribing information. Cytokinetics Incorporated; 2026. Accessed August 5, 2026. https://cytokinetics.com/wp-content/uploads/2025/12/MYQORZO_US_Prescribing_Information_and_Med_Guide.pdf
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. JACC. 2024;149(23):1524-4539. doi:10.1161/CIR.0000000000001250

DISCLAIMER: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgement in providing the most appropriate care for their patients.