CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Indiana Medicaid

DRUG NAME	Myqorzo (aficamten)
BENEFIT TYPE	Pharmacy
STATUS	Prior Authorization Required

Myqorzo is a cardiac myosin inhibitor initially approved by the FDA in December 2025. Myqorzo is used for the treatment of symptomatic obstructive hypertrophic cardiomyopathy (oHCM) in adults to improve functional capacity and symptoms.

Symptomatic obstructive hypertrophic cardiomyopathy is a genetic cardiac condition characterized by abnormal thickening of the heart muscle, leading to obstruction of blood flow from the left ventricle. oHCM is recognized as one of the most common genetic cardiovascular disorders, with an estimated prevalence of approximately 1 in 500 individuals in the general population. Despite its genetic basis, many individuals remain asymptomatic or experience mild symptoms, leading to underdiagnosis. The condition can be presented differently with symptoms such as dyspnea, chest pain, syncope, and palpitations.

The approval of Myqorzo was supported by the phase 3 SEQUOIA-HCM trial, which demonstrated that Myqorzo significantly improved peak oxygen uptake compared to the placebo.

Myqorzo (aficamten) will be considered for coverage when the following criteria are met:

Symptomatic Obstructive Hypertrophic Cardiomyopathy (oHCM)

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with a cardiologist; AND
3. Member has a diagnosis of obstructive hypertrophic cardiomyopathy (oHCM) confirmed by an echocardiography or cardiovascular magnetic resonance imaging (CMR); AND
4. Member has documentation of New York Heart Association (NYHA) class II-III symptoms; AND
5. Member has a left ventricular outflow tract gradient (LVOT-G) ≥ 50 mmHg; AND
6. Member has left ventricular ejection fraction (LVEF) ≥55%; AND
7. Member has tried and failed a beta-blocker, verapamil, or diltiazem; AND
8. Member is NOT concurrently taking rifampin.
9. **Dosage allowed/Quantity limit:** Initiate 5mg orally once daily. Maintenance dosage must be individualized based on echocardiographic assessments and clinical status. Max dose 20 mg once daily. QL: 30 tablets per 30 days.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must show improvement, or stabilized signs and symptoms of disease (i.e. reduction of symptoms, improvement in mixed pVO2 or NYHA classification improvement).

If all the above requirements are met, the medication will be approved for 12 months.

CareSource considers Myqorzo (aficamten) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
01/13/2026	New policy for Myqorzo created.

References:

1. Myqorzo (aficamten). Prescribing information. Cytokinetics; 2025. Accessed January 30, 2026.https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/219083s000lbl.pdf
2. Maron MS, Masri A, Nassif ME, et al. Aficamten for Symptomatic Obstructive Hypertrophic Cardiomyopathy. *New England journal of medicine/□The □New England journal of medicine*. 2024;390(20). doi:https://doi.org/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. Circulation. 2024;149(23). doi:https://doi.org/10.1161/cir.0000000000001250
4. 2021 Georgia Code Title 33 – Insurance Chapter 20A - Managed Health Care Plans Article 2 - Patient's Right to Independent Review § 33-20A-31 Definitions. Justia US Law. Accessed April 25, 2023. https://law.justia.com/codes/georgia/2021/title-33/chapter-20a/article-2/section-33-20a-31/.

Effective date: 07/01/2026
Revised date: 01/13/2026