289 LaClair Coos Bay OR 97420
Phone: 541-269-7400 Fax: 541-269-7147

Cardiac Myosin Inhibitors Drug Use Criteria

Created: October 2026
Reviewed: October 2026

Includes:

Medication	Dosage forms	
Myqorzo (aficamten)	Tablets: 5 mg, 10 mg, 15 mg, 20 mg	Prior authorization; quantity limit 1 tablet/day; MYQORZO REMS-certified specialty pharmacy
Camzyos (mavacamten)	Capsules: 2.5 mg, 5 mg, 10 mg, 15 mg	Prior authorization; quantity limit 1 capsule/day; CAMZYOS REMS-certified specialty pharmacy

GUIDELINE FOR USE:

Initial Request:

1. Is this a request to renew a previously approved cardiac myosin inhibitor authorization?

   a. If yes: Go to Renewal Criteria.
   b. If no: Go to 2.

2. Does the request meet the FDA-labeled population for the selected product: Myqorzo for an adult, or Camzyos for an adult or pediatric member weighing at least 30 kg?

   a. If yes: Go to 3.
   b. If no: Deny or request a product appropriate for the member's age and weight.

3. Is the requested product prescribed by or in consultation with a cardiologist experienced in hypertrophic cardiomyopathy?

   a. If yes: Go to 4.
   b. If no: Deny

289 LaClair Coos Bay OR 97420
Phone: 541-269-7400 Fax: 541-269-7147

4. Is symptomatic obstructive hypertrophic cardiomyopathy documented? For adults, are NYHA class II or III symptoms documented?

a. If yes: Go to 5.
b. If no: Deny. The adult NYHA requirement does not apply to an otherwise qualifying pediatric Camzyos request.

5. Does a baseline echocardiogram document left ventricular ejection fraction (LVEF) of at least 55%?

a. If yes: Go to 6.
b. If no: Deny as not meeting criteria. Initiate when LVEF is below 55% is not recommended in FDA labeling.

6. Is there documentation of a peak left ventricular outflow tract gradient (LVOT-G) of at least 50 mmHg at rest or with provocation?

a. If yes: Go to 7.
b. If no: Deny as not meeting criteria.

7. Has the member had an adequate trial of, intolerance to, or contraindication to at least one first-line agent: a beta-blocker AND a non-dihydropyridine calcium channel blocker (verapamil or diltiazem)?

a. If yes: Go to 8.
b. If no: Deny, step therapy not met.

8. For an adult request, has the member had a trial of, intolerance to, or contraindication to disopyramide?

a. If yes: Go to 9. Pediatric Camzyos requests bypass this step.
b. If no: For adults, deny unless disopyramide is clinically inappropriate. This proposed step does not apply automatically to pediatric patients.

9. Are the prescriber and member enrolled in the REMS for the requested product, and will dispensing occur through a pharmacy certified for that product?

a. If yes: Go to 10.
b. If no: Deny until the applicable MYQORZO REMS or CAMZYOS REMS requirements are satisfied.

289 LaClair Coos Bay OR 97420
Phone: 541-269-7400 Fax: 541-269-7147

10. Were pregnancy considerations and all medications and supplements reviewed against the selected product's FDA interaction and contraindication requirements?

- **a. If yes:** Go to 11.
- **b. If no:** Deny or clarify. Myqorzo is contraindicated with rifampin; Camzyos has separate CYP contraindications and embryo-fetal toxicity precautions.

11. Is the requested strength, starting dose, titration plan, and echocardiographic monitoring schedule consistent with the selected product's current FDA labeling and REMS?

- **a. If yes:** Approve for 6 months with a quantity limit of 1 dosage unit per day and dispensing through the applicable REMS-certified specialty pharmacy.
- **b. If no:** Deny or request correction.

Renewal Request:

1. Did the member meet the initial approval criteria?

- **a. If yes:** Go to 2.
- **b. If no:** Review under Initial Authorization criteria.

2. Is there documented clinical benefit, such as reduced symptoms, improved or stable NYHA class, improved functional capacity, or reduced LVOT obstruction?

- **a. If yes:** Go to 3.
- **b. If no:** Deny

3. Is the member under continued care of a cardiologist and compliant with the applicable product-specific REMS?

- **a. If yes:** Go to 4.
- **b. If no:** Deny until requirements are satisfied.

289 LaClair Coos Bay OR 97420
Phone: 541-269-7400 Fax: 541-269-7147

4. Do current echocardiographic results and clinical status support continued treatment, with product-specific dose adjustment or interruption performed when required?

a. **If yes:** Go to 5.
b. **If no:** Deny or obtain clarification. Myqorzo directs dose reduction when LVEF is below 50% and at least 40%, and interruption below 40% or with worsening clinical status due to systolic dysfunction. Camzyos directs interruption when LVEF is below 50% or clinical status worsens.

5. Is the requested dose within FDA-labeled dosing and monitoring requirements?

a. **If yes:** Approve for 12 months with a quantity limit of 1 dosage unit per day and REMS-certified specialty-pharmacy dispensing.
b. **If no:** Deny or request correction.

Required Echocardiographic Monitoring: Follow the FDA-labeled echocardiographic schedule and REMS authorization process for the selected product. For Myqorzo, assess 2–8 weeks after initiation or dose adjustment; after maintenance is established, assess every 6 months, or every 3 months when LVEF is below 55% and at least 50%. For Camzyos, use the current CAMZYOS label and REMS schedule, including additional monitoring after clinically significant interaction changes or when heart-failure risk increases.

Authorization Duration: Initial authorization: 6 months. Renewal: 12 months. Each product must be dispensed by a pharmacy certified under its own REMS. Product substitution requires a new product-specific safety and dosing review; Myqorzo and Camzyos are not interchangeable dosage forms.

Rationale: To promote safe and cost-effective step-therapy management of symptomatic obstructive hypertrophic cardiomyopathy. To ensure optimization of established, lower-cost formulary alternatives, including beta-blockers, verapamil, diltiazem, and, when clinically appropriate, disopyramide, before initiating a cardiac myosin inhibitor. To ensure cardiac myosin inhibitors are used in members with documented symptomatic disease and clinically significant left ventricular outflow tract obstruction. Continued coverage will require evidence of clinical benefit, ongoing cardiology management, and compliance with product-specific REMS and echocardiographic monitoring requirements. These requirements are intended to reduce the risk of left ventricular systolic dysfunction, heart failure, clinically significant drug interactions, and inappropriate continuation of therapy.

FDA-Approved Indication: Myqorzo: treatment of adults with symptomatic obstructive hypertrophic cardiomyopathy (oHCM) to improve functional capacity and symptoms. Camzyos:

289 LaClair Coos Bay OR 97420
Phone: 541-269-7400 Fax: 541-269-7147

treatment of adults and pediatric patients weighing at least 30 kg with symptomatic oHCM to improve functional capacity and symptoms.

References:

1. U.S. Food and Drug Administration. *MYQORZO (aficamten) tablets: Prescribing Information*. NDA 219083. Revised December 2025. Accessed October 11, 2026.
2. U.S. Food and Drug Administration. *MYQORZO Risk Evaluation and Mitigation Strategy (REMS)*. NDA 219083. Initial approval December 2025. Accessed October 11, 2026.
3. U.S. Food and Drug Administration. *CAMZYOS (mavacamten) capsules: Prescribing Information*. NDA 214998. Current FDA-approved version. Accessed October 11, 2026.
4. U.S. Food and Drug Administration. *CAMZYOS Risk Evaluation and Mitigation Strategy (REMS)*. Current FDA-approved version. Accessed October 11, 2026.
5. U.S. Food and Drug Administration. FDA approves first drug to improve functional capacity and symptoms in children with rare inherited heart condition. Published September 30, 2026. Accessed October 11, 2026.
6. 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:10.1161/CIR.0000000000001250.
7. Maron MS, Masri A, Nassif ME, et al; SEQUOIA-HCM Investigators. Aficamten for symptomatic obstructive hypertrophic cardiomyopathy. *N Engl J Med*. 2024;390(20):1849-1861. doi:10.1056/NEJMoa2401424.
8. Olivotto I, Oreziak A, Barriales-Villa R, et al; EXPLORER-HCM Study Investigators. Mavacamten for treatment of symptomatic obstructive hypertrophic cardiomyopathy (EXPLORER-HCM): a randomized, double-blind, placebo-controlled, phase 3 trial. *Lancet*. 2020;396(10253):759-769. doi:10.1016/S0140-6736(20)31792-X.