

DRUG POLICY

Camzyos® (mavacamten) and Myqorzo™ (aficamten)

BENEFIT APPLICATION

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This medical policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

DESCRIPTION

The intent of the policy is to provide coverage consistent with product labeling, FDA guidance, standards of medical practice, evidence-based drug information, and/or published guidelines. The indications below including FDA-approved indications and compendial uses are considered covered benefits provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

Camzyos is indicated for the treatment of adults with symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy (oHCM) to improve functional capacity and symptoms.

Myqorzo is indicated for the treatment of adults with symptomatic obstructive hypertrophic cardiomyopathy (oHCM) to improve functional capacity and symptoms.

POLICY

Required Documentation

Submission of the following information is necessary to initiate the prior authorization review:

1. Initial requests:
 - a. Imaging reports, laboratory results, chart notes or medical record documentation supporting left ventricular wall thickness of greater than or equal to 15 mm, OR left ventricular wall thickness of greater than or equal to 13 mm in members with familial hypertrophic cardiomyopathy or in conjunction with a positive genetic test (e.g., MYH7, MYBPC3, TNNI3, TNNT2, TPM1, MYL2, MYL3, ACTC1 gene variants) (if applicable).
 - b. Chart notes or medical record documentation supporting baseline left ventricular ejection fraction (LVEF) $\geq 55\%$, baseline Valsalva left ventricular outflow tract (LVOT) peak gradient ≥ 50 mmHg, and baseline resting left ventricular outflow tract (LVOT) gradient ≥ 30 mmHg (if applicable)

- c. Chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
2. Continuation requests:
 - a. Chart notes or medical record documentation supporting that the member has achieved or maintained a positive clinical response to therapy (e.g., increase in peak oxygen consumption [pVO₂], New York Heart Association (NYHA) class reduction).
 - b. Chart notes or medical record documentation supporting that left ventricular ejection fraction (LVEF) $\geq$ 50%.

Prescriber Specialties

The requested medication must be prescribed by or in consultation with one of the following:

1. Cardiologist

Criteria for Initial Approval

Obstructive Hypertrophic Cardiomyopathy (Camzyos)

1. Authorization of 3 months for Camzyos may be granted for treatment of obstructive hypertrophic cardiomyopathy when all of the following criteria are met:
 - A. Member has one of the following:
 - i. Left ventricular wall thickness of greater than or equal to 15 mm anywhere in the left ventricle, OR
 - ii. Left ventricular wall thickness of greater than or equal to 13 mm anywhere in the left ventricle in members with familial hypertrophic cardiomyopathy or in conjunction with a positive genetic test (e.g., MYH7, MYBPC3, TNNI3, TNNT2, TPM1, MYL2, MYL3, ACTC1 gene variants)
 - B. Member has NYHA functional class II-III symptoms (see Appendix)
 - C. Member must have a baseline left ventricular ejection fraction (LVEF) $\geq$ 55% and baseline Valsalva left ventricular outflow tract (LVOT) peak gradient $\geq$ 50 mmHg
 - D. Member has experienced an inadequate response to a beta-adrenergic antagonist (e.g., atenolol, metoprolol) or non-dihydropyridine calcium channel blocker (e.g., diltiazem, verapamil) at maximally tolerated dose or has an intolerance or contraindication to both therapies.

Obstructive Hypertrophic Cardiomyopathy (Myqorzo)

1. Authorization of 12 months for Myqorzo may be granted for treatment of obstructive hypertrophic cardiomyopathy when all of the following criteria are met:
 - A. Member has one of the following:
 - i. Left ventricular wall thickness of greater than or equal to 15 mm anywhere in the left ventricle, OR
 - ii. Left ventricular wall thickness of greater than or equal to 13 mm anywhere in the left ventricle in members with familial hypertrophic cardiomyopathy or in conjunction with a positive genetic test (e.g., MYH7, MYBPC3, TNNI3, TNNT2, TPM1, MYL2, MYL3, ACTC1 gene variants)
 - B. Member has NYHA functional class II-III symptoms (see Appendix)
 - C. Member must have a baseline left ventricular ejection fraction (LVEF) $\geq$ 55% and both of the following:
 - i. Baseline resting left ventricular outflow tract (LVOT) gradient $>$ 30 mmHg
 - ii. Baseline Valsalva left ventricular outflow tract (LVOT) peak gradient $\geq$ 50 mmHg
 - D. Member has experienced an inadequate response to a beta-adrenergic antagonist (e.g., atenolol, metoprolol) or non-dihydropyridine calcium channel blocker (e.g., diltiazem,

verapamil) at maximally tolerated dose, or has an intolerance or contraindication to both therapies.

E. Member cannot use the requested medication concomitantly with rifampin.

Continuation of Therapy

Obstructive Hypertrophic Cardiomyopathy

1. Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for obstructive hypertrophic cardiomyopathy when all the of the following criteria are met where applicable:
 - A. The member achieved or maintained a positive clinical response to therapy (e.g., increase in pVO₂, NYHA class reduction)
 - B. The member has a left ventricular ejection fraction (LVEF) $\geq$ 50%
 - C. Member cannot use the requested medication concomitantly with rifampin (Myqorzo only)

Other

Camzyos (mavacamten) and Myqorzo (aficamten) are considered **not medically necessary** for members who do not meet the criteria set forth above.

Members currently receiving the requested medication as samples or via the manufacturer's patient assistance program will be required to meet the criteria for initial approval. This ensures that members are treated equally regardless of their provider's ability to access medication samples.

Dosing and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Quantity Limits Apply

Medication	Standard Limit	FDA Recommended Dosing
Camzyos (mavacamten) 2.5 mg oral capsule	1 capsule per day	Starting dose is 5 mg orally once daily without regard to food; allowable subsequent doses with titration are 2.5 mg, 5 mg, 10 mg, or 15 mg orally once daily.
Camzyos (mavacamten) 5 mg oral capsule		
Camzyos (mavacamten) 10 mg oral capsule		
Camzyos (mavacamten) 15 mg oral capsule		
Myqorzo (aficamten) 5 mg oral tablet	1 tablet per day	Starting dose is 5 mg orally once daily. Increase the dose every 2 to 8 weeks by 5 mg until a maintenance dose or the maximum recommended dose of 20 mg once daily is achieved.
Myqorzo (aficamten) 10 mg oral tablet		
Myqorzo (aficamten) 15 mg oral tablet		
Myqorzo (aficamten) 20 mg oral tablet		

Appendices

New York Heart Association (NYHA) Functional Classification	
Class I	No limitations of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea (shortness of breath)
Class II	Slight limitation of physical activity. Comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea (shortness of breath) or chest pain.
Class III	Marked limitation of physical activity. Comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea (shortness of breath) or chest pain.
Class IV	Unable to carry on any physical activity without discomfort. Symptoms of heart failure at rest. If any physical activity is undertaken, discomfort increases.

PROCEDURES AND BILLING CODES

To report provider services, use appropriate CPT* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.

REFERENCES

- Camzyos [package insert]. Princeton, NJ: Bristol Myers Squibb Company; April 2025.
- Myqorzo [package insert]. South San Francisco, CA: Cytokinetics Incorporated; December 2025.
- Ommen SR, Ho CY, Balaji S, 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):e1239-e1311.
- “Classes and Stages of Heart Failure.” American Heart Association. 7 June 2023. <https://www.heart.org/en/health-topics/heart-failure/what-is-heart-failure/classes-of-heart-failure>. Accessed December 22, 2025.
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- Maron MS, Masri A, Nassif ME, et al. Aficamten for symptomatic obstructive hypertrophic cardiomyopathy. *N Engl J Med*. 2024;390(20):1849-1861.
- Arbelo E, Protonotarios A, Gimeno JR, et al. 2023 ESC guidelines for the management of cardiomyopathies. *Eur Heart J*. 2023;44(37):3503-3626.

POLICY HISTORY

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