

Louisiana Medicaid Aficamten (Myqorzo™)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for aficamten (Myqorzo™).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available [HERE](#).

Approval Criteria for Initiation of Therapy

- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of obstructive hypertrophic cardiomyopathy (HCM); **AND**
- Obstructive HCM for this recipient is symptomatic New York Heart Association (NYHA) Class II or III [must be **stated on the request**]; **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a cardiologist; **AND**
- The recipient has had an inadequate response, intolerance, adverse reaction, or contraindication to beta blockers or calcium channel blockers (medication name and treatment dates must be **stated on the request**); **AND**
- The recipient has a documented left ventricular ejection fraction (LVEF) $\geq 55\%$ prior to initiation of aficamten (LVEF value must be **stated on the request**).

Duration of approval for initiation of therapy: 6 months

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient has evidence of a positive response to therapy; **AND**
- The prescriber **states on the request** that the recipient is being monitored for left ventricular ejection fraction (LVEF), Valsalva left ventricular outflow tract gradient (LVOT-G) assessment, and heart failure symptoms and has not developed any contraindications or other adverse drug effects that may exclude continued use.

Duration of approval for continuation of therapy: 12 months

References

Myqorzo (aficamten) [package insert]. San Francisco, CA: Cytokinetics, Incorporated; December 2025. https://cytokinetics.com/wp-content/uploads/2025/12/MYQORZO_US_Prescribing_Information_and_Med_Guide.pdf

Ommen SR, 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:e1239.

Revision / Date	Implementation Date
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