PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

9/9/2026	<%PANumber%>

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS

Myqorzo - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Myqorzo - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Myqorzo (aficamten)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Will the requested medication be used for any other uses that are not Food and Drug Administration (FDA)-approved or guideline-supported? Y N

NOTE: Submission of medical records is required.

	[If yes, no further questions.]
2.	Will the requested medication be concurrently used with another cardiac myosin inhibitor? Y N
	[If yes, no further questions.]
3.	Will the requested medication be concurrently used with rifampin? Y N
	[If yes, no further questions.]
4.	Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N
	NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.
	[If no, skip to question 8.]
5.	Is there a new echocardiogram left ventricular ejection fraction (LVEF) assessment? Y N
	NOTE: Submission of medical records is required.
	[If no, no further questions.]
6.	Is there documentation showing the patient has had a positive response to treatment? Y N
	NOTE: Submission of medical records is required.
	[If no, no further questions.]
7.	Does the patient have left ventricular ejection fraction (LVEF) less than 40 percent, symptomatic heart failure, or worsening clinical status? Y N
	NOTE: Submission of medical records is required.
	[No further questions.]
8.	Does the patient have a diagnosis of symptomatic obstructive hypertrophic cardiomyopathy (HCM) confirmed by echocardiogram or cardiac magnetic resonance? Y N
	NOTE: Submission of medical records is required.
	[If no, no further questions.]
9.	Is the diagnosis due to a known infiltrative or storage disorder causing cardiac hypertrophy that mimicked obstructive HCM (i.e., Fabry disease, amyloidosis, or Noonan syndrome with left ventricular hypertrophy)? Y N
	NOTE: Submission of medical records is required.
	[If yes, no further questions.]
10.	Does the patient have a New York Heart Association (NYHA) Class II or III functional status? Y N
	NOTE: Submission of medical records is required.
	[If no, no further questions.]
11.	Does the patient have a left ventricular ejection fraction (LVEF) of greater than or equal to 55 percent? Y N

NOTE: Submission of medical records is required.	
[If no, no further questions.]	
12. Does the patient have a left ventricular outflow tract (LVOT) peak gradient of greater than or equal to 30 mmHg at rest or greater than or equal to 50 mmHg after provocation?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
13. Has the patient had a trial and an inadequate response to BOTH of the following: A) non-vasodilating beta blocker (i.e., atenolol, bisoprolol, metoprolol), and B) non-dihydropyridine calcium channel blocker (i.e., verapamil, diltiazem)?	Y N
NOTE: Submission of medical records is required.	
[If yes, skip to question 15.]	
14. Is there a clinical reason why patient cannot used BOTH of the following: A) non-vasodilating beta blocker (i.e., atenolol, bisoprolol, metoprolol), and B) non-dihydropyridine calcium channel blocker (i.e., verapamil, diltiazem)?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
15. Is the patient 18 years of age or older?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date