USFHP Prior Authorization Request Form for
aficamten (Myqorzo)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007
https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior authorization expires in 12 months. Initial TRICARE PA approval is required for renewal. Coverage will be approved indefinitely.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.*	☐Yes (subject to verification) Proceed to question **10**	☐No Proceed to question **2**
2. Is the patient 18 years of age or older?	☐Yes Proceed to question **3**	☐No **STOP** **Coverage not approved**
3. Is the requested medication being prescribed by a cardiologist?	☐Yes Proceed to question **4**	☐No **STOP** **Coverage not approved**
4. Does the patient have documented evidence of obstructive hypertrophic cardiomyopathy (HCM)?	☐Yes Proceed to question **5**	☐No **STOP** **Coverage not approved**
5. Does the patient have left ventricular outflow tract (LVOT-G) gradient GREATER THAN OR EQUAL TO 30 mmHg at rest or GREATER THAN OR EQUAL TO 50 mmHg after the Valsalva maneuver?	☐Yes Proceed to question **6**	☐No **STOP** **Coverage not approved**

6. Does the patient have New York Heart Association (NYHA) Class II to III obstructive hypertrophic cardiomyopathy that is symptomatic (for example, dyspnea, chest pain, lightheadedness, syncope, fatigue, reduced exercise capacity)?	☐Yes Proceed to question **7**	☐No **STOP** **Coverage not approved**
***7.* Does the patient have left ventricular ejection fraction (LVEF) GREATER THAN OR EQUAL TO 55%?**	☐Yes Proceed to question **8**	☐No **STOP** **Coverage not approved**
8. Has the patient failed therapy with AT LEAST ONE agent from both classes: beta blocker (non-vasodilating) propranolol, metoprolol AND calcium channel blockers (non-dihydropyridine) verapamil or diltiazem?	☐Yes Proceed to question **9**	☐No **STOP** **Coverage not approved**
9. Will the requested medication be used concomitantly with Camzyos?	☐Yes **STOP** **Coverage not approved**	☐No **Sign and date below**
10. Has the patient responded to therapy, as evidenced by improvement in obstructive hypertrophic cardiomyopathy symptoms?	☐Yes **Sign and date below**	☐No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date