



# **Mavacamten for Hypertrophic Cardiomyopathy: Effectiveness and Value**

**Evidence Report**

**October 7, 2021**

**Prepared for**



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None of the above authors disclosed any conflicts of interest defined as more than \$10,000 in health care company stock or more than \$5,000 in honoraria or consultancies relevant to this report during the previous year from health care manufacturers or insurers.

## DATE OF

**PUBLICATION:** October 7, 2021

**How to cite this document:** Wasfy JH, Walton SM, Beinfeld M, Nhan E, Sarker J, Whittington M, Pearson SD, Rind DM. Mavacamten for Hypertrophic Cardiomyopathy: Effectiveness and Value; Evidence Report. Institute for Clinical and Economic Review, October 7, 2021.

<https://icer.org/hypertrophic-cardiomyopathy-2021/>.

Jason H. Wasfy served as the lead author for the report. Molly Beinfeld led the systematic review and authorship of the comparative clinical effectiveness section in collaboration with Emily Nhan. Surrey M. Walton developed the cost-effectiveness model and authored the corresponding sections with assistance from Jyotirmoy Sarker. Melanie Whittington provided oversight of the cost-effectiveness analyses and developed the budget impact model. Steven D. Pearson and David M. Rind provided methodologic guidance on the clinical and economic evaluations. We would also like

to thank Laura Cianciolo, Maggie Houle, and Mrinmayee Joshi (University of Illinois at Chicago) for their contributions to this report.

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The funding for this report comes from government grants and non-profit foundations, with the largest single funder being the Arnold Ventures. No funding for this work comes from health insurers, pharmacy benefit managers, or life science companies. ICER receives approximately 29% of its overall revenue from these health industry organizations to run a separate Policy Summit program, with funding approximately equally split between insurers/pharmacy benefit managers and life science companies. There are no life science companies relevant to this review who participate in this program. For a complete list of funders and for more information on ICER's support, please visit <https://icer.org/who-we-are/independent-funding/>.

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*In the development of this report, ICER’s researchers consulted with several clinical experts, patients, manufacturers, and other stakeholders. The following experts provided input that helped guide the ICER team as we shaped our scope and report. It is possible that expert reviewers may not have had the opportunity to review all portions of this draft report. None of these individuals is responsible for the final contents of this report, nor should it be assumed that they support any part of it. The report should be viewed as attributable solely to the ICER team and its affiliated researchers.*

*For a complete list of stakeholders from whom we requested input, please visit: [https://icer.org/wp-content/uploads/2021/05/ICER\\_HCM\\_Stakeholder\\_List\\_050721.pdf](https://icer.org/wp-content/uploads/2021/05/ICER_HCM_Stakeholder_List_050721.pdf).*

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*No relevant conflicts of interest to disclose, defined as more than \$10,000 in health care company stock or more than \$5,000 in honoraria or consultancies during the previous year from health care manufacturers or insurers.*

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*The Hypertrophic Cardiomyopathy Association receives 20% of its sponsorship for educational programming from Bristol Myers Squibb/MyoKardia.*

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## List of Acronyms and Abbreviations Used in this Report

AHRQ	Agency for Healthcare Research and Quality
CDC	Centers for Disease Control and Prevention
CI	Confidence interval
cm	Centimeter
cMRI	Cardiac magnetic-resonance imaging
CPET	Cardiopulmonary exercise testing
evLY	Equal value of life years
FDA	Food and Drug Administration
HCM	Hypertrophic cardiomyopathy
HCMSQ [SoB]	Hypertrophic Cardiomyopathy Symptom Questionnaire [Shortness of Breath]
HOCM/OHCM	Hypertrophic obstructive cardiomyopathy
HRQoL	Health-related quality of life
hs-cTnI	High-sensitivity cardiac troponin I
ICD	Implantable cardioverter defibrillator
ICER	Institute for Clinical and Economic Review
IQR	Interquartile range
KCCQ [OS][CS]	Kansas City Cardiomyopathy Questionnaire [overall summary][clinical summary]
kg	Kilogram
L	Liter
LVEF	Left ventricular ejection fraction
LVOT	Left ventricular outflow tract
mg	Milligram
mL	Milliliter
mm	Millimeter
mm Hg	Millimeter of mercury
MRI	Magnetic-resonance imaging
ms	Millisecond
N	Total number
n	Number
N/A	Not applicable
ng	Nanogram
NR	Not reported
NT-proBNP	N-terminal pro B-type natriuretic peptide
NYHA	New York Heart Association
P/I	Promising but inconclusive
PICOTS	Population, Intervention, Comparator, Outcomes, Timing, Setting
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
pVO <sub>2</sub>	Peak oxygen consumption
QALY	Quality-adjusted life year
SD	Standard deviation
SoC	Standard of care
US	United States
USPSTF	United States Preventive Services Task Force

# Executive Summary

---

Hypertrophic cardiomyopathy (HCM) is a genetic disorder involving sarcomeres in heart muscle that can cause symptoms such as chest discomfort and shortness of breath, particularly with exertion. Additional symptoms can include palpitations, dizziness, and syncope (passing out). Although many patients with HCM have a normal life expectancy without symptoms, even patients without symptoms are at risk of sudden cardiac death. Apart from managing symptoms, key components of therapy include placement of implanted cardioverter defibrillators (ICDs) for patients at high risk of sudden death and anticoagulation for patients who have both HCM and atrial fibrillation.

For patients with a specific subtype of HCM, hypertrophic obstructive cardiomyopathy (HOCM), obstruction of the left ventricular outflow tract (LVOT) can be an important contributor to exertional symptoms. The LVOT is the conduit through which blood exits the heart to the rest of the body. Among the effects of dynamic narrowing of the LVOT are increased pressure within the left ventricle, increased myocardial oxygen demand, and increased mitral regurgitation. While LVOT obstruction is one important target for therapy to reduce symptoms, there are other causes of symptoms (including in non-obstructive HCM patients) including diastolic dysfunction, microvascular angina (obstruction of small heart artery vessels), and irregular heart rhythms.

For HOCM patients with shortness of breath related to LVOT obstruction, medications can improve symptoms. Beta blockers and calcium channel blockers reduce the forcefulness of the heart's contraction, reducing the LVOT gradient, thus improving symptoms. However, beta blockers and calcium channel blockers have important side effects, including fatigue that can interfere with work or daily activities, dizziness, and sexual dysfunction.

When these first-line therapies are insufficient or not well tolerated, second-line treatment options include adding disopyramide or performing septal reduction procedures. Disopyramide has important side effects as well, and drug shortages limit access to the long-acting version. Septal reduction procedures include surgical myectomy (a type of open-heart surgery) or alcohol septal ablation, a controlled heart attack that reduces the thickness of the heart muscle causing LVOT obstruction. Those procedures can have substantial benefit, but they have a low but meaningful risk of death. Furthermore, clinical outcomes following these procedures may be worse outside centers of excellence. As such, there is substantial unmet need for the management of exertional symptoms in patients with symptomatic HOCM, particularly among patients that do not have good access to specialized centers.

A novel agent, mavacamten, has been tested in clinical trials. Mavacamten reduces adenosine triphosphatase activity in cardiac myosin heavy chain, one of the proteins in heart muscle cells, and thus reduces the contraction of the heart that can contribute to obstruction. A United States (US) Food and Drug Administration (FDA) decision on approval of mavacamten is expected in early 2022.

This report examines the comparative effectiveness and cost effectiveness of mavacamten in patients with symptomatic HOCM.

The key trial in such patients is EXPLORER, a Phase III randomized trial comparing mavacamten to placebo in 251 patients receiving first-line treatments. Mavacamten was more effective than placebo at meeting a primary composite endpoint of 1.5 mL/kg per min or greater increase in peak oxygen consumption ( $pVO_2$ ) and at least one New York Heart Association (NYHA) class reduction or a 3.0 mL/kg per min or greater  $pVO_2$  increase without NYHA class worsening (37% vs. 17%,  $p=0.0005$ ). Among patients who completed the Kansas City Cardiomyopathy Questionnaire (KCCQ),<sup>1</sup> the KCCQ overall summary score was more improved among patients assigned to mavacamten than placebo (+14.9 vs. +5.4,  $p<0.0001$ ). Serious adverse events were uncommon in EXPLORER and similar between arms of the trial. Some clinical experts noted conceptual concerns about reductions in ejection fraction and myocardial thickness with mavacamten: these changes can be beneficial but could result in long-term harm if they persist or recover then worsen over time. Other clinical experts are much less concerned about this potential harm. In the absence of additional long-term evidence on mavacamten, we need to consider the potential for possible net harms, and we rate mavacamten in addition to usual care compared with usual care alone as *promising but inconclusive* (“P/I”).

When comparing mavacamten with disopyramide, we are limited by the absence of head-to-head randomized trials and the absence of randomized trials of disopyramide. Disopyramide has known side effects and contraindications. Furthermore, data supporting use of disopyramide are relatively weak and potentially exaggerate the true treatment effect due to study design. On balance, we consider the evidence for mavacamten compared with disopyramide to be *promising but inconclusive* (“P/I”) as well.

We lack randomized trials of septal reduction therapies either to each other, compared with no procedure, or compared with mavacamten. Observational data appear to show greater improvements in functional outcomes with such procedures than was seen in the EXPLORER trial, however, these procedures have a small risk of short-term serious adverse events including death. Overall, among patients who are eligible for a septal reduction procedure, net benefits are likely greater with a procedure than with mavacamten. However, we also believe the choice between a procedure with a short-term risk of death and mavacamten would be highly dependent on individual patient preferences. Given this, we are not assigning an evidence rating to this comparison: such decisions will need to be made on a case-by-case basis through discussions among patients, families, and clinicians.

**Table ES1. Evidence Ratings**

Treatment	Comparator	Evidence Rating
<b>Mavacamten Plus Beta Blockers and Calcium Channel Blockers</b>	Beta blockers and calcium channel blockers alone	P/I
<b>Mavacamten Plus Beta Blockers and Calcium Channel Blockers</b>	Disopyramide	P/I
<b>Mavacamten Plus Beta Blockers and Calcium Channel Blockers</b>	Septal reduction therapies	See discussion in Section 3.3

P/I: promising but inconclusive

For more information on the rationale for these evidence ratings, please see [Section 3.3](#).

We created a semi-Markov model to estimate discounted lifetime time horizon costs, quality-adjusted life years (QALYs), life years, years in NYHA class I, and equal value of life years (evLYs) for mavacamten along with standard first-line therapies and several comparators. Table ES2 presents the base-case cost-effectiveness results.

**Table ES2. Incremental Cost-Effectiveness Ratios for Mavacamten\* in the Base Case**

Treatment	Comparator	Cost per QALY Gained	Cost per Life Year Gained	Cost per evLY Gained	Cost per Additional NYHA I Year
<b>Mavacamten</b>	Standard treatment	\$1,200,000	Undefined	\$1,200,000	\$219,000
	Disopyramide	\$1,500,000	Undefined	\$1,500,000	\$278,000
	Myectomy	Dominated	\$5,600,000	N/A†	Dominated
	Septal ablation	Dominated	\$7,000,000	N/A†	Dominated

evLY: equal value of life years, N/A: not applicable, NYHA: New York Heart Association, QALY: quality-adjusted life year

\*Price assumed for mavacamten was a placeholder of \$75,000 per year.

†Incremental cost per evLY gained not applicable due to fewer lifetime QALYs for mavacamten as compared to myectomy and septal ablation.

Mavacamten used along with standard first-line treatment was projected to generate higher amounts of QALYs than standard first-line treatment alone. However, at the placeholder cost of \$75,000, the incremental cost-effectiveness ratio was well above standard thresholds (\$1,200,000 per QALY). When compared with disopyramide, the incremental cost per QALY was even higher, and mavacamten was found to be dominated by both myectomy and septal ablation. From the cost-effectiveness analysis, we estimated the health benefit price benchmark (HBPB) for mavacamten to be \$12,000 to \$15,000 annually. The actual cost effectiveness of mavacamten will depend on its price.

Potential other benefits of mavacamten include more access to treatment options because septal reduction procedures are mainly available at specialized centers. When septal reduction procedures are performed at lower-volume centers, outcomes are worse<sup>2</sup> although these differences could reflect both differences in quality and/or unmeasured confounding. There have

also been national shortages of the long-acting form of disopyramide. In part based on the shortage as well as other issues including side effects and limited efficacy, few patients are actually taking disopyramide.<sup>3</sup> However, some patients and patient groups emphasized that disopyramide is still an important treatment option. Finally, mavacamten will be a new option available for patients at points in their lives when they are making important life choices regarding education, work, and raising families, which could provide benefits over and above the improvement in QALYs calculated in the model.

# 1. Background

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Hypertrophic cardiomyopathy (HCM) is a heart muscle disorder that can cause symptoms such as chest discomfort and shortness of breath, particularly with exertion. Although many patients with HCM have a normal life expectancy without symptoms, even patients without symptoms are at risk of sudden cardiac death. Patients with HCM who develop atrial fibrillation are at elevated risk of stroke.<sup>4</sup> The mechanisms that cause patients to have exertional symptoms are diverse and can include diastolic dysfunction (difficulty filling the heart with blood) and microvascular angina (obstruction of small heart artery vessels) as well as other causes.

HCM is a condition with different subtypes. For patients with hypertrophic obstructive cardiomyopathy (HOCM), which is one of the subtypes of HCM, narrowing and obstruction of the left ventricular outflow tract (LVOT) can occur with exertion or sometimes at rest. The LVOT is the conduit through which blood begins to exit the heart. Since this type of obstruction can interfere with the heart's pumping function, it is a major cause of exertional symptoms for patients with the HOCM subtype of HCM. However, not all exertional symptoms are caused by LVOT obstruction even among the subset of HCM patients with HOCM.

The underlying cause of HCM is dysfunction in proteins called sarcomeres that help cardiac muscle cells (myocytes) squeeze and pump blood.<sup>5</sup> The sarcomere dysfunction in HCM can lead to hypertrophy (thickening) of the heart. HCM can occur due to a number of heritable genetic defects affecting sarcomere proteins. Hypertrophy related to sarcomere dysfunction distinguishes HCM from other forms of cardiac conditions, such as hypertrophy caused by chronic high blood pressure, infiltrative disorders such as cardiac amyloidosis, or healthy adaptive hypertrophy from athletic training. As such, doctors often need to perform tests to distinguish HCM from other forms of hypertrophy; in some cases, the diagnosis can be difficult to make. Specific single-gene mutations in 15 genes have been identified as associated with HCM,<sup>6</sup> although patients can have the clinical appearance of HCM (phenotypic HCM) without an identified gene mutation.

Because of difficulties with detection, the observed prevalence of HCM varies in studies conducted with different methods. Asymptomatic patients may only be diagnosed with HCM when an imaging test is performed for a different reason. An estimate using echocardiographic screening suggested a prevalence of HCM of one in 500,<sup>7</sup> but screening with cardiac magnetic-resonance imaging (cMRI), which is more sensitive and specific for cardiac hypertrophy, found a prevalence of about one in 70.<sup>8</sup> Not all patients with HCM mutations develop hypertrophy. Guidelines for the treatment of patients with HCM were most recently published in 2020.<sup>9</sup> With appropriate selection of higher-risk patients for implantable cardioverter defibrillators (ICDs), which can shock the heart out of dangerous heart rhythms, the risk of sudden cardiac death has declined to 0.5% per year.<sup>10</sup> When patients develop atrial fibrillation, anticoagulation is generally recommended to prevent cardioembolic stroke regardless of conventional stroke risk factors. For HOCM patients with

exertional symptoms thought to be related to the LVOT gradient, principles of therapy involve reducing the magnitude of the LVOT gradient, which generally improves symptoms. Pharmacological approaches involve therapies that reduce cardiac contractility (negative inotropic agents) including beta blockers and calcium channel blockers.<sup>11</sup> For patients who still have symptoms or who are unable to tolerate these agents, adding disopyramide as a second-line agent and invasive strategies such as septal myectomy (open-heart surgery to remove a portion of heart muscle) or alcohol septal ablation (a controlled heart attack to reduce the heart muscle tissue in the obstructed area) are considered.<sup>11</sup> No randomized trial has compared surgical myectomy to septal ablation, but guidelines favor surgical myectomy in most patients.<sup>9</sup>

A novel agent, mavacamten, has been tested in clinical trials. Mavacamten is a direct myosin inhibitor and an oral medication administered once per day that directly reduces adenosine triphosphatase activity in cardiac myosin heavy chain, one of the proteins in heart muscle cells.<sup>12</sup> This is a key step in how heart muscle cells make energy for contracting the heart.<sup>12</sup>

A United States (US) Food and Drug Administration (FDA) decision on approval of mavacamten is expected in early 2022. Multispecialty guidelines were most recently revised in 2020 and, as such, do not yet specify the role of mavacamten in HCM.<sup>13</sup> Any use of mavacamten will likely occur in symptomatic HOCM patients who are refractory or intolerant to beta blocker and calcium channel blockers. Given that evidence does not yet exist comparing mavacamten to disopyramide, surgical myectomy, or septal ablation, clinical experts differ about the role of mavacamten as an alternative to those strategies. A randomized trial, VALOR-HCM (NCT04349072), is evaluating the use of mavacamten to reduce utilization of septal reduction procedures in patients who would otherwise be eligible for invasive therapies. As such, this trial is not designed to provide a direct comparison of up-front septal reduction procedures versus mavacamten.<sup>14</sup>

Given that the mechanism of action addresses the underlying pathophysiology of sarcomeric dysfunction, the cause of HCM, it remains conceptually possible that mavacamten may reduce symptoms for patients with HCM without obstruction. The MAVERICK-HCM trial demonstrated improvement in cardiac biomarkers, which are known surrogates for myocardial wall stress.<sup>15</sup> These therapeutic concepts are mechanistically appealing and could lead to further trials with clinical endpoints including symptoms. Other therapeutic concepts for HCM are in development and validation. For example, sacubitril/valsartan attenuates cardiac fibrosis and hypertrophy in a rat model of myocardial infarction.<sup>16</sup> Since these processes are key aspects of the pathophysiology of HCM, ongoing trials are evaluating the clinical effectiveness of sacubitril/valsartan in HCM without obstruction.<sup>17</sup> Additionally, other myosin inhibitors are being evaluated<sup>18</sup> with results of a Phase II trial of aficamten (REDWOOD-HCM, NCT04219826) recently reported at a conference in September 2021.



## 2. Patient and Caregiver Perspectives

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ICER met virtually with patients with HCM, representatives from patient organizations, and clinical experts to understand patient and caregiver perspectives and unmet needs, contextual considerations, and outcomes important to patients with all types of HCM, including symptomatic HOCM. Dr. Jason H. Wasfy also participated in the 2020 American College of Cardiology Roundtable on Advances in Hypertrophic Cardiomyopathy to gain additional perspective.

Finally, to obtain more detailed information about patient, family, and caregiver perspectives, ICER conducted a national survey in partnership with the Hypertrophic Cardiomyopathy Association, the nation's most prominent organization providing support, advocacy, and education for patients with HCM. This survey encouraged free-text responses from HCM patients, allowing flexibility to express diverse perspectives. Responses were coded using qualitative methods to identify common themes and both common themes and direct patient quotes were reported. Of 641 total responses, 606 were from HCM patients, 29 were from caregivers and/or family members, and six were from patient advocates. Many patients and caregivers emphasized difficulties accessing specialized HCM centers, finding cardiology subspecialists knowledgeable about HCM, and difficulties with insurance. Patients reported substantial financial burdens associated with travel, co-payments, and high deductibles. Patients also reported a variety of symptoms including fatigue, exertional intolerance, and difficulty breathing. About a third of patients reported that their current treatments “work okay” and nearly a tenth report that their current treatments “do not work,” suggesting a large unmet need related to symptoms. Many patients on treatments including beta blockers, calcium channel blockers, and disopyramide reported fatigue. Detailed information about the survey methods and both qualitative and quantitative results are presented in [Section B of the Report Supplement](#).

The spectrum of severity of illness in HCM is wide, and many patients do not have severe symptoms (see [Report Supplement Section B](#)). For many other patients with HCM, the burden of disease can be severe. In addition to the relatively small risk of sudden cardiac death for most HCM patients, about one in six patients develop exertional symptoms.<sup>19</sup> Both patients with HCM generally and with HOCM can have these exertional symptoms, and among patients with HOCM, a larger outflow tract gradient is associated with a higher likelihood of having symptoms.<sup>19</sup> Patients with HOCM also face anxiety, depression, and concerns about activities of daily living and social events. There is uncertainty about the extent to which exercise can increase the risk of sudden cardiac death for HOCM patients, and guidelines have shifted over time,<sup>13</sup> allowing recommendations for more athletic activity for HOCM patients. These changes have led to uncertainty and confusion among HOCM patients about optimal self-care. Since patients often have electrocardiograms and echocardiograms that mimic other conditions, including acute myocardial infarction and hypertensive heart disease, misdiagnosis is common and patients with HCM often have frustrations

with the health care system. This can be minimized with care at large high-volume centers of excellence, but many patients do not have access to these centers because of cost and location. The total cost of care for symptomatic patients with HOCM is greater than six times that of patients of similar age and gender.<sup>20</sup>

Patients and their representatives particularly highlighted exertional symptoms. Patients were most concerned with how symptoms impair everyday functioning and prevent them from living their lives. The cornerstones of therapy, beta blockers and calcium channel blockers, have important limitations. In the survey, one patient told us:

*“I think the medications cause fatigue and brain fog that prompted me to take an early retirement from work as I felt I was not capable of performing my work tasks to full capability/commitment.”*

For another patient, a single mother, the fatigue caused by beta blockers made caring for her children more difficult:

*“I was a single mom on beta blockers and had a hard time doing anything – my kids needed me to drive, make meals, etc., and sometimes I was just too tired.”*

Patients also expressed concerns about representing functional status with New York Heart Association (NYHA) classification in part because of concerns about the term “heart failure.” Furthermore, patients emphasized that there is a “good day, bad day” phenomenon in symptomatic HOCM, since symptoms can vary substantially from day-to-day, and this variation is not well described by NYHA class. Clinical experts expressed additional concerns with NYHA class, including that patients may underreport clinical symptoms. As such, objective patient-reported outcomes were preferred when possible. Patients also emphasized that HCM is not “traditional” heart failure, with very different treatments and prognoses even though some symptoms, including exertional dyspnea, are similar.

Some patients described the fear of sudden cardiac death. Although most patients have a normal life expectancy, early studies reported higher mortality rates. This fear has substantial effects on patients’ life choices. Particularly when patients are diagnosed early in life, uncertainty and fear can lead to pressured life decisions about educational programs, marriage and relationships, and decisions about whether to have children. Patients reported concern about passing along genes associated with HCM to children. Patients also reported concerns about convincing children (who are sometimes adults at time of the patient’s diagnosis) to receive screening. In addition, patients reported that the diagnosis of HOCM can lead to difficulties receiving life insurance, being admitted to educational programs, and receiving loans. In that context, patients reported feeling reluctant to discuss their condition for fear of being misunderstood. One patient told us, “I was living with a flopping, living fish in my chest and there was no one around to talk about it.” Public focus on

prominent athletes' deaths also takes away attention from other patient concerns, such as obstruction, exertional symptoms, and traditional heart failure in later-stage HCM.

Palpitations with arrhythmias was a common source of concern for patients. Many patients reported feeling much worse when having irregular heart rhythms, and they reported fear about how to distinguish dangerous from less dangerous heart rhythms. Some patients and their friends and families consider buying automated electronic defibrillators, which are expensive, to reduce the risk of sudden cardiac death.

Patients with HOCM also reported substantial difficulties interacting with caregivers, clinics, and hospitals. According to the Hypertrophic Cardiomyopathy Association's Patient-Focused Drug Development Meeting report, "The underlying emotional toll for HCM patients can be intense and can cripple...a sense of wellbeing."<sup>21</sup> Given that HCM is a less common condition, many physicians do not understand how to manage it, and physicians sometimes overestimate risk. The electrocardiogram pattern for many patients with HCM can mimic a heart attack and, as such, many patients reported inappropriate escalations in care that would have been avoided with better access to HCM-specific expertise. Patients also reported worse access for non-cardiac ambulatory procedures (such as office-based colonoscopy) because of caregiver fear of cardiac complications. Fainting in public places is often a source of severe distress because patients need to advocate for themselves and give directions to both bystanders and emergency personnel given their unique circumstances.

A common concern was the organization and availability of centers of excellence. Access to procedural care for surgical myectomy and septal ablation is limited because these procedures are only performed at highly specialized centers. The excellent outcomes for these procedures represent care delivered at these centers and may not be generalizable to other settings. The Hypertrophic Cardiomyopathy Association has developed an assessment model that has identified 42 centers of excellence for HCM. Patients from rural areas, patients with less money to travel, and people of color may have disproportionately less access to these centers. Black patients in particular have less access to septal reduction therapies and genetic testing.<sup>22</sup> Furthermore, women are referred to subspecialty HCM care later than men.<sup>23</sup>

Many patients noted concern about underdiagnosis, since HCM can often be asymptomatic or misdiagnosed. Patients in different racial and socioeconomic groups have differential access to cardiac imaging used for diagnosis.

Patients and patient groups report concern about the financial burden to both patients and patient caregivers. Patients and patient groups are specifically concerned about the potential cost of mavacamten including cost-sharing arrangements such as co-payments. When caregivers are needed to provide care for HCM patients, they sometimes cannot work, exacerbating financial problems. Patients themselves are often underemployed because they fear moving to new jobs or

communities because these moves could disrupt insurance, social supports, and access to caregivers.

## 3. Comparative Clinical Effectiveness

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### 3.1. Methods Overview

Procedures for the systematic literature review assessing the evidence on mavacamten for symptomatic HOCM are detailed in [Section D1 of the Report Supplement](#).

#### Scope of Review

We reviewed the clinical effectiveness of mavacamten plus usual care versus usual care alone, disopyramide, and septal reduction therapies. Usual care is defined as beta blockers and/or calcium channel blockers. We sought evidence on patient-important outcomes, including functional status and health-related quality of life (HRQoL). We also sought evidence on changes NYHA class, echocardiographic parameters, peak oxygen consumption ( $pVO_2$ ), left ventricular ejection fraction (LVEF), and serum cardiac biomarkers. The full scope of the review is detailed in [Section D1 of the Report Supplement](#).

#### Evidence Base

##### *Mavacamten*

Evidence informing our review of mavacamten in symptomatic HOCM was derived from one Phase III randomized controlled trial and one Phase II trial. Due to differences in trial design and outcomes assessed, the Phase II trial was not the primary focus of review and is described in detail in [Section D2 of the Report Supplement](#). A randomized trial of mavacamten in symptomatic non-obstructive HCM, which is outside the scope of this review, is described in [Section D2 of the Report Supplement](#).

EXPLORER-HCM was a multi-center Phase III trial that randomized 251 patients with HOCM in a 1:1 ratio to 5-15 mg oral mavacamten or placebo (Table 3.1).<sup>24,25</sup> Patients were eligible to participate if they were 18 years of age or older, met the criteria for HOCM based on current American College of Cardiology/American Heart Association guidelines,<sup>9</sup> and had documented LVEF  $\geq 55\%$  and NYHA class II-III symptoms. Patients were excluded if they were on current treatment with disopyramide or had been treated with septal reduction therapy (myectomy or septal ablation) within six months prior to screening. Randomization was stratified by four baseline clinical characteristics: NYHA class, beta blocker use, ergometer type (treadmill or bicycle), and consent for a cardiovascular MRI sub-study. All patients received mavacamten or placebo over a 30-week treatment period. Cardiopulmonary exercise testing (CPET) and post-exercise echocardiography were performed at screening and week 30, while resting echocardiography, electrocardiograms, and lab tests were performed every two to four weeks across 12 visits.

The primary outcome was a composite outcome of an objective physiological parameter as well as a clinician-estimated clinical measure to assess clinical response, defined as  $\geq 1.5$  mL/kg per min increase in  $pV_{O_2}$  *and*  $\geq 1$  NYHA class reduction *or*  $\geq 3.0$  mL/kg per min increase in  $pV_{O_2}$  *and* no worsening of NYHA class.<sup>26</sup>

Secondary outcomes included change from baseline to 30 weeks in post-exercise LVOT gradient,  $pV_{O_2}$ , NYHA improvement, and HRQoL. Exploratory outcomes included N-terminal pro B-type natriuretic peptide (NT-proBNP) and high-sensitivity cardiac troponin I (hs-cTnI). Safety outcomes included treatment-emergent adverse events and serious adverse events.

Participants in the EXPLORER-HCM trial had a mean age of 58.5 years and were predominantly male and white (91%). In the mavacamten group, a minority of patients (9%) had undergone septal reduction therapy and all but 3% were taking background medication (beta blockers or calcium channel blockers). Most patients in both arms (72-74%) were classified as having NYHA class II symptoms at baseline. The study arms were balanced across baseline characteristics, with a few exceptions. The mavacamten arm included a greater percentage of female participants than the placebo arm (46% vs. 35%), fewer participants with a history of atrial fibrillation (10% vs. 18%), and had a higher mean NT-proBNP (777 vs. 616 ng/L) (Table 3.1). Additional information about the trial population is available in [Table D4](#) and [Table D14](#) of the Report Supplement.

The EXPLORER trial also included a five-year extension study (MAVA-LTE) to evaluate the long-term safety and efficacy of mavacamten. At the time of the report, only interim results from MAVA-LTE were available.<sup>27</sup>

**Table 3.1. Selected Baseline Characteristics of the Randomized Controlled Trial of Mavacamten, Retrospective Study of Disopyramide, and Systematic Review of Septal Reduction Therapies<sup>28-30</sup>**

	Randomized Controlled Trial of Mavacamten (EXPLORER)		Retrospective Study of Disopyramide (Sherrid 2005)		Systematic Review of Septal Reduction Therapies (Liebregts 2015)	
	Mavacamten (n=123)	Placebo (n=128)	Disopyramide (n=118)	Non-Disopyramide (n=373)	Septal Ablation (n=2,791)	Myectomy (n=2,013)
Age, Mean (SD)	58.5 (12.2)	58.5 (11.8)	47 (20)	43 (21)	56 (54-58)*†	47 (40-47)†
Female Gender, n (%)	57 (46)*	45 (35)	NR (49)	NR (47)	NR (49)*	NR (40)
Medical History, n (%):						
Atrial Fibrillation	12 (10)*	23 (18)	NR (20)	NR (18)	NR	NR
Septal Reduction Therapy	11 (9)	8 (6)	NR (28)	NR (18)	NR	NR
ICD	27 (22)	29 (23)	NR (5)	NR (2)	NR (3)	NR (10)
Background Therapy, n (%):						
Beta Blocker	94 (76)	95 (74)	NR (98)*	NR (70)	NR	NR
Calcium Channel Blocker	25 (20)	17 (13)	NR (32)	NR (27)	NR	NR
Neither	4 (3)	16 (13)	NR	NR	NR	NR
NYHA Class I, n (%)	0 (0)	0 (0)	14 (12)	NR	2.8 (2.8-3)†	2.9 (2.7-3.1)†
NYHA Class II, n (%)	88 (72)	95 (74)	59 (50)	NR		
NYHA Class III, n (%)	35 (28)	33 (26)	45 (38)	NR		

ICD: implantable cardioverter defibrillator, n: number, NR: not reported, NYHA: New York Heart Association, SD: standard deviation

\*Indicates a statistically significant difference between groups.

†Reported value is weighted median (interquartile range).

### **Disopyramide**

Evidence on disopyramide is very limited. To inform our review of disopyramide, we describe one retrospective study of 118 patients with HOCM treated with disopyramide at four US-based specialized HCM centers between 1990 and 1999 and 373 patients not treated with disopyramide during the same time period. Patients were followed for a mean of 4.2 years ( $\pm 2.9$  months).<sup>29</sup> At baseline, patients treated with disopyramide had a mean age of 47 years ( $\pm 20$ ), 28% had undergone septal reduction therapy, 98% were on beta blockers, and 50% had NYHA class II symptoms (Table 3.1). Additional baseline characteristics of this study and information about other studies of disopyramide are discussed in [Section D2 of the Report Supplement](#).

### **Septal Reduction Therapies**

Evidence to inform our review of septal reduction therapies (myectomy and septal ablation) came from existing systematic literature reviews. A 2015 review with meta-analysis pooled long-term outcomes from 24 studies comprising 16 myectomy cohorts (mean follow-up 7.4 years) and 11 septal ablation cohorts (mean follow-up 6.2 years).<sup>30</sup> Patients in the septal ablation cohorts were older than in the myectomy cohorts (56 years compared to 47,  $p=0.0009$ ) and more likely to be female (49% female compared to 40%,  $p=0.058$ ) (Table 3.1). Additional baseline characteristics and

systematic reviews of septal reduction therapy are discussed in [Section D2 of the Report Supplement](#).

One major challenge in assessing comparative effectiveness for symptomatic HOCM is that while randomized data exist to compare mavacamten versus beta blockers and calcium channel blockers, there are not randomized data for comparisons of mavacamten versus either disopyramide or septal reduction therapies.

## 3.2. Results

### Clinical Benefits

#### *Mavacamten*

##### Clinical Response

Clinical response was achieved by 45 (37%) patients in the mavacamten arm at 30 weeks compared to 22 (17%) in the placebo arm ( $p=0.0005$ ).<sup>24</sup>

##### NYHA Class, LVOT Gradients, LVEF, and $pVO_2$

Thirty-two (27%) patients in the mavacamten group achieved NYHA class I status and all LVOT peak gradients  $<30$  mm Hg at 30 weeks compared to one patient (1%) in the placebo group, a difference of 26.6% (95% confidence interval [CI]: 18.3-34.8) (Table 3.2).

Improvement in NYHA by at least one class at 30 weeks was reported in 80 (65%) patients in the mavacamten group and 40 (31%) in the placebo group ( $p<0.0001$ ) (Table 3.2).<sup>24</sup> At baseline, no patients in either treatment arm had a NYHA class I. By week 30, 49.6% of patients in the mavacamten group achieved NYHA class I status compared to 21.1% of patients in the placebo group. Furthermore, the proportion of patients with a NYHA class III status declined from 28.5% at baseline to 6.5% at 30 weeks in the mavacamten group and from 25.8% to 19.5% in the placebo group (Table 3.3). In the long-term extension study of mavacamten (MAVA-LTE), continued improvements in NYHA class were observed. At week 48, 29 of 49 (59%) patients on mavacamten reached NYHA class I.<sup>27</sup>

Changes in post-exercise and resting LVOT gradients from baseline to 30 weeks in the mavacamten and placebo groups are presented in Table 3.2. Improvements in resting LVOT gradient and Valsalva LVOT gradient were sustained out to 60 weeks in the long-term extension study (MAVA-LTE).<sup>27</sup>



Mean decrease in LVEF was -3.9% in the mavacamten group compared to -0.01% with placebo, a -4% difference (95% CI: -5.5 to -2.5) (Table 3.2).<sup>24</sup> These changes in LVEF were sustained in the long-term extension study (MAVA-LTE).<sup>27</sup>

Mean increase in pVO<sub>2</sub> was 1.4 mL/kg per min greater in the mavacamten group than in the placebo group (95% CI: 0.6-2.1; p=0.0006) (Table 3.2).<sup>24</sup>

### Cardiac Biomarkers

Mean NT-proBNP declined from 777.4 ng/L at baseline to 163.1 ng/L at 30 weeks in the mavacamten group and increased from 615.7 ng/L at baseline to 645.9 ng/L at 30 weeks in the placebo group (proportion of geometric mean ratio between the two groups 0.202, 95% CI: 0.169-0.241) (Table 3.2).<sup>24</sup> NT-proBNP levels were sustained in the long-term extension study (MAVA-LTE). At week 60, median NT-proBNP was 153 ng/L.<sup>27</sup> Mean hs-cTnI started at 12.5 ng/L in both groups and declined to 7.4 ng/L in the mavacamten group at 30 weeks and remained constant at 12.6 ng/L in the placebo group (proportion of geometric mean ratio between the two groups 0.589, 0.500-0.693) (Table 3.2).<sup>24</sup>

**Table 3.2. EXPLORER-HCM Key Trial Results<sup>24</sup>**

Outcome at 30 Weeks	Mavacamten (n=123)	Placebo (n=128)
NYHA Class I and All LVOT Peak Gradients <30 mm Hg, n/N (%)	32/117 (27)	1/126 (1)
NYHA Class Improvement ≥1, n (%)	80 (65)	40 (31)
LVOT, Post-Exercise Peak Gradient <50 mm Hg, n/N (%)	75/101 (74)	22/106 (21)
LVOT, Post-Exercise, Change from Baseline Mean mm Hg (SD)	-47 (40)	-10 (30)
LVOT Gradient, Resting, Change from Baseline Mean mm Hg	-37.6	-5.2
LVEF, Resting, Change from Baseline, %	-3.9	-0.01
pVO <sub>2</sub> Change from Baseline, Mean mL/kg per min (SD)	1.4 (3.1)	-0.1 (3.0)
NT-proBNP, Geometric Mean, Change from Baseline, ng/mL	-614.3	30.2
Hs-CTnI, Geometric Mean, Change from Baseline, ng/L	-5.1	0.1

Hs-CTnI: High-Sensitivity Cardiac Troponin I, kg: kilogram, L: liter, LVEF: left ventricular ejection fraction, LVOT: left ventricular outflow tract, mL: milliliter, mm Hg: millimeter of mercury, NT-proBNP: N-terminal pro B-type natriuretic peptide, n: number, N: total number, ng: nanogram, NYHA: New York Heart Association, pVO<sub>2</sub>: peak oxygen consumption, SD: standard deviation

**Table 3.3. Distribution of NYHA Class, Baseline, and 30 Weeks in the EXPLORER Trial<sup>24</sup>**

	Mavacamten (n=123)		Placebo (n=128)	
	Baseline	30 Weeks	Baseline	30 Weeks
NYHA Class I (%)	0	49.6	0	21.1
NYHA Class II (%)	71.5	42.3	74.2	57.8
NYHA Class III (%)	28.5	6.5	25.8	19.5
Missing (%)	0	1.6	0	1.6

NYHA: New York Heart Association

### Patient-Reported Quality of Life

In EXPLORER, patient health status (with a focus on symptoms, physical and social function, and quality of life) was assessed using the Kansas City Cardiomyopathy Questionnaire (KCCQ), a validated cardiomyopathy-specific instrument,<sup>31</sup> and the HCM Symptom Questionnaire (HCMSQ) at baseline and weeks six, 12, 18, 30 (end of treatment), and 38 weeks (end of study, after an eight-week washout period).<sup>1</sup>

Greater improvements in KCCQ overall summary, clinical summary, physical limitation, and quality-of-life scores from baseline (positive is better) were observed for patients in the mavacamten group compared to the placebo group (Table 3.4). These changes at 30 weeks from baseline were all greater than the minimal clinically important difference, estimated to be between 4 and 6 points across all domains.<sup>32</sup> All improvements in KCCQ at 30 weeks reversed to baseline eight weeks after withdrawal of treatment during the washout period.<sup>1</sup>

Mean improvements in the HCMSQ-Shortness-of-Breath (HCMSQ-SoB) sub-score from baseline (negative is better) were  $-2.8 \pm 2.7$  in the mavacamten group compared to  $-0.9 \pm 2.4$  (least square mean difference  $-1.8$ , 95% CI:  $-2.4$  to  $-1.2$ ).<sup>24</sup>

**Table 3.4. EXPLORER-HCM Change in Selected KCCQ Scores from Baseline<sup>1</sup>**

Outcome at 30 Weeks	Mavacamten (n=92)	Placebo (n=88)	Least Square Mean Differences (95% CI)
Overall Summary Score, Mean (SD)	14.9 (15.8)	5.4 (13.7)	9.1 (5.5-12.8)
Clinical Summary Score, Mean (SD)	13.6 (14.4)	4.2 (13.9)	9.1 (5.5-12.7)
Physical Limitation Score, Mean (SD)	14.7 (17.0)	3.6 (15.4)	10.6 (6.2-14.8)
Quality of Life Score, Mean (SD)	18.8 (21.6)	8.3 (18.8)	9.6 (4.7-14.5)

CI: confidence interval, n: number, SD: standard deviation

### **Disopyramide**

In the retrospective study, of the 118 patients treated with disopyramide, 40 (34%) required major interventions (myectomy, septal ablation, or dual-chamber pacing) a mean of  $2.0 \pm 2.1$  years after initiating drug treatment because of inadequate symptom control, persistent gradients, drug intolerance, or withdrawal. Among patients who did not require an intervention and remained on treatment during the follow-up period, mean peak flow gradient decreased from 75 mm Hg ( $\pm 30$ ) at baseline to 40 mm Hg ( $\pm 32$ ) ( $p < 0.0001$ ), and mean NYHA class declined from 2.3 ( $\pm 0.7$ ) to 1.7 ( $\pm 0.6$ ) ( $p < 0.0001$ ). Among patients who required an intervention, disopyramide was not associated with improvements in NYHA class and modest improvements in peak LVOT gradient (Table 3.5). These outcomes were not reported in the non-disopyramide patients.<sup>29</sup>

Annualized all-cardiac death was 1.4% in the 118 disopyramide-treated patients and 2.6% in the 373 non-disopyramide-treated patients (p=0.07). Annualized sudden death was 1.0% in the disopyramide group and 1.8% in the non-disopyramide group (p=0.08).<sup>29</sup>

**Table 3.5. Key Results of Retrospective Study of Disopyramide<sup>29</sup>**

Outcome	Disopyramide without Intervention (n=78)		Disopyramide with Intervention (n=40)	
	Baseline	Follow-Up	Baseline	Follow-Up
Peak LVOT Gradient, Mean mm Hg (SD)	75 (33)	40 (32)	73 (35)	63 (31)
NYHA Class, Mean (SD)	2.3 (0.7)	1.7 (0.6)	2.3 (0.7)	2.3 (0.6)
NYHA Class Distribution, n (%)	I: 9 (12) II: 40 (51) III/IV: 29 (37)	I: 29 (37) II: 42 (54) III/IV: 7 (9)	NR	NR

LVOT: left ventricular outflow tract, mm Hg: millimeter of mercury, n: number, NR: not reported, NYHA: New York Heart Association, SD: standard deviation

### ***Septal Reduction Therapies***

In the 2015 systematic review with meta-analysis of septal reduction therapies, the pooled median percentage reduction in NYHA class after both septal ablation and myectomy was 45% and the median proportion of patients remaining in NYHA class III/IV was 8% after septal ablation and 5% after myectomy (p=0.43). Median LVOT gradient reduction was 71% after septal ablation and 77% after myectomy (p=0.63). More patients in the septal ablation cohorts required reintervention than in the myectomy cohorts (7.7% compared to 1.6%, p=0.001) (Table 3.6).<sup>30</sup> In a 2020 systematic review with meta-analysis of septal reduction therapies, the pooled mean difference in NYHA class before and after treatment was -1.16 (-1.43 to -0.90) after septal ablation, -1.51 (-1.69 to -1.33) for myectomy, and -1.31 (-1.69 to -1.33) across both therapies.<sup>33</sup>

**Table 3.6. Selected Pooled Outcomes in Studies of Septal Reduction Therapies<sup>30</sup>**

	Septal Ablation	Myectomy
NYHA, % Reduction, Weighted Median (IQR)	45 (45-50)	45 (44-48)
Remaining in NYHA III/IV, %, Weighted Median (IQR)	8 (8-8)	4.5 (4.5-12)
LVOT Gradient, mm Hg, % Reduction, Weighted Median (IQR)	71 (67-90)	77 (69-90)
Re-Intervention, Weighted Median (IQR)*	7.7 (4.2-11.1)	1.6 (0.6-2.6)

IQR: interquartile range, LVOT: left ventricular outflow tract, mm Hg: millimeter of mercury, NYHA: New York Heart Association

\*Indicates a statistically significant difference between groups.

## Harms

### *Mavacamten*

In the EXPLORER trial, 88% of participants in the mavacamten group reported any treatment-emergent adverse event compared to 79% in the placebo arm. Common adverse events included ventricular tachycardia, atrial fibrillation, palpitations, cardiac failure, and angina. Eleven serious adverse events were reported by 10 (8%) patients in the mavacamten group versus 20 serious events reported by 11 (9%) in the placebo group. Serious adverse events leading to discontinuation were reported by 1.6% of participants in the mavacamten group versus 0.8% in the placebo arm (Table 3.7).<sup>24</sup>

The study protocol required temporary treatment discontinuation for LVEF less than 50%, excessive QT interval, and mavacamten plasma concentration >1,000 ng/mL. During the study period, three patients on mavacamten and two patients on placebo temporarily discontinued due to LVEF decreases to less than 50% and an additional four patients on mavacamten had LVEF less than 50% at week 30. In three of the four patients, the LVEF returned to normal, and in one patient, severe systolic dysfunction developed after an atrial fibrillation ablation with complications. One of these patients in the mavacamten group had a procedural complication after ablation for atrial fibrillation and severe LVEF decrease, but partially recovered to LVEF 50% during the washout period. Three patients on mavacamten and three patients on placebo temporarily discontinued due to changes in QT interval. No patients discontinued due to mavacamten plasma levels. All patients who discontinued during the study period resumed treatment.<sup>24</sup>

In the long-term extension study of mavacamten (MAVA-LTE, n=224), no additional safety concerns were reported. Treatment-emergent adverse events were reported by 141 participants (62.9%). Serious adverse events were reported by 19 (8.5%), and two patients (0.9%) discontinued due to adverse events.<sup>27</sup>

**Table 3.7. Overview of Safety Data for EXPLORER at 30 Weeks<sup>24,34</sup>**

	<b>Mavacamten (n=123)</b>	<b>Placebo (n=128)</b>
<b>Treatment-Emergent Adverse Events, n (%)</b>	108 (88)	101 (79)
<b>Serious Adverse Events, n (%)</b>	10 (8)	11 (9)
<b>Discontinuation, n (%)</b>	4 (3.3)	3 (2.3)
<b>Adverse Events Leading to Discontinuation, n (%)</b>	2 (1.6)	1 (0.8)
<b>Cardiac Serious Adverse Events, n (%)</b>	4 (3.3)	4 (3.1)

n: number

## Disopyramide

As an antiarrhythmic agent, disopyramide has known risks of proarrhythmia. However, in a multi-center retrospective study of disopyramide, sudden cardiac death was similar in the disopyramide-treated patients (1.4%) and non-disopyramide-treated patients (2.6%,  $p=0.07$ ). It is possible that there was selection bias with patients at greater risk of arrhythmia being less likely to receive disopyramide.<sup>29</sup> In a single-site retrospective study focusing on the safety of disopyramide, QT interval was prolonged by a mean 19 ms compared to baseline. The proportion of patients with QT prolongation  $\geq 460$  ms was 16% at baseline and 33% after disopyramide.<sup>35</sup>

Additional substantial concerns with disopyramide are drug-related side effects and treatment discontinuation.

Detailed harms of disopyramide were not reported in Sherrid 2005, however, eight patients (7%) discontinued due to intolerance, such as dry mouth ( $n=5$ ) and prostatism ( $n=3$ ).<sup>29</sup> In a single-site retrospective study, of 168 patients with HOCM who were started on disopyramide, 38 (23%) reported side effects. These side effects included anticholinergic effects ( $n=27$ ), weakness and fatigue ( $n=50$ ), and nausea ( $n=1$ ). Eighteen (11%) discontinued the drug due to side effects. More information on harms of disopyramide are available in [Table D30 of the Report Supplement](#).

## Septal Reduction Therapies

The most important safety concern with septal reduction therapies is procedure-related harms. In a 2015 systematic with meta-analysis of septal reduction therapies, pooled peri-procedural mortality ( $<30$  days) was 1.3% in the septal ablation cohorts and 2.5% in the myectomy cohorts ( $p=0.051$ ). In addition, in-hospital outcomes are worse at lower-volume centers.<sup>2</sup> Peri-procedural adverse arrhythmic events, including sustained ventricular tachycardia and ventricular fibrillation, were 2.2% in the septal ablation cohorts and 1.0% in the myectomy cohorts ( $p=0.091$ ). The need for permanent pacemaker implantation was higher in the septal ablation cohorts compared to the myectomy cohorts (10% vs. 4.4%,  $p<0.001$ ) (Table 3.8).<sup>30</sup>

**Table 3.8. Pooled Safety Outcomes in Studies of Septal Reduction Therapies<sup>30</sup>**

	Septal Ablation	Myectomy
Peri-Procedural Mortality ( $<30$ Days), %, Weighted Mean (95% CI)	1.3 (0.7-1.8)	2.5 (1.4-3.6)
Peri-Procedural Adverse Arrhythmic Events, %	2.2	1.0
Cardiac Mortality, %, Weighted Mean	1.1	2.5
Permanent Pacemaker Implantation, %, Weighted Mean (95% CI)*	10 (7.8-12.1)	4.4 (2.6-6.2)

CI: confidence interval

## Subgroup Analyses and Heterogeneity

In the EXPLORER trial, treatment effects for mavacamten across most subgroups were consistently indistinguishable from the average treatment effect with the exception that patients receiving concomitant beta blockers in addition to mavacamten were less likely than patients not on beta blockers to achieve the primary composite endpoint of complete response (30% vs. 59%). It is unclear whether this treatment interaction was related to a blunting of the effect of mavacamten or to how the primary endpoint was assessed since it included exercise testing.<sup>24</sup> There was no statistically significant difference in the primary endpoint for men versus women. Although outcomes are not reportedly separately by race, there were only six Black patients, one Native American or Alaska Native patient, and six Asian patients in the trial.

We sought evidence on the effectiveness of mavacamten in subgroups of interest such as in children, specific genetic variants of HOCM, and non-obstructive HCM, however, the evidence was not available or not sufficient to assess effectiveness in these populations. Data from the MAVERICK trial on the effectiveness of mavacamten in non-obstructive HCM are described in [Table D10 of the Report Supplement](#).<sup>27</sup>

In the retrospective study of disopyramide, modest improvements in peak gradient and no improvement in NYHA class was observed in the subgroup of patients who required invasive interventions compared to the subgroup of patients who stayed on drug treatment.<sup>29</sup>

In the 2015 systematic review with meta-analysis of septal reduction studies, septal ablation was associated with fewer peri-procedure complications than myectomy, but greater need for reintervention and permanent pacemaker implantation.<sup>30</sup>

## Uncertainty and Controversies

While mavacamten improved physiologic parameters and symptoms in the EXPLORER trial, the available data are mostly short term, and symptomatic HOCM, once it appears, can last a lifetime. Clinical experts differed on whether the reductions in ejection fraction with mavacamten reflected beneficial improvements in cardiac function, including healthy remodeling, or worrisome changes that could be associated with clinical harm with longer observation times. Rapid loss of improvements in quality of life when mavacamten was stopped suggest that neither of these may be occurring, although any regression in physiological measurements (such as peak VO<sub>2</sub>) is unclear. In a Phase II trial of a different myosin inhibitor, aficamten, two patients had transient reduction in LVEF.<sup>18</sup> Longer-term data are needed to understand if this has prognostic importance.

More than 90% of patients in EXPLORER were white leaving questions about the representativeness of the study population and the external validity of the results. Also, the mean age in the trial was 58.5, but treatment can be needed in younger patients. As such, the external validity of these

results in real-world populations is uncertain. Trials have inclusion and exclusion criteria that are different than patients who receive a treatment in actual practice. Results from real-world use after FDA approval will help assess these potential concerns.

While patients and patient groups and some clinical experts have identified disopyramide as an important later-line medical therapy for HOCM and an important comparator for mavacamten,<sup>36</sup> it has not been studied in high-quality randomized trials, either against placebo or against mavacamten, limiting the ability to make direct or indirect comparisons of the agents. The largest retrospective multicenter analysis reports treatment effects for disopyramide among patients who did not have major interventions such as dual-chamber pacing or septal reduction therapy.<sup>29</sup> In addition, patients who received major interventions did not have improvement with disopyramide before receiving interventions. As such, the reported treatment effect among patients who did not receive interventions is larger than the actual treatment effect among all patients. In addition, this analysis reports changes in symptoms as measured by NYHA class when patients initially presented for evaluation at a specialized HCM center (rather than immediately before starting disopyramide). Both of these effects likely exaggerate the reported efficacy of disopyramide in this analysis although the direction of bias is uncertain. Furthermore, patients enrolled in this retrospective, real-world analysis at four referral centers likely differ from patients enrolled in EXPLORER. These issues pose problems for the comparison of mavacamten to disopyramide.<sup>36</sup>

There are also not randomized data comparing surgical myectomy to septal ablation or comparing either type of septal reduction therapy to mavacamten. An ongoing randomized trial is examining whether mavacamten can reduce the need for septal reduction procedures,<sup>14</sup> but this does not directly assess the relative benefits of mavacamten and such procedures. Even in patients who are otherwise indifferent to the varying benefits and risks of a procedure or a medication, the lack of direct randomized evidence of the procedures versus mavacamten (or the procedures vs. one another) limits the ability to make rigorous comparisons. Furthermore, it is unclear whether the results of septal procedures at centers of excellence, where many patient series are from, can be generalized to other centers.

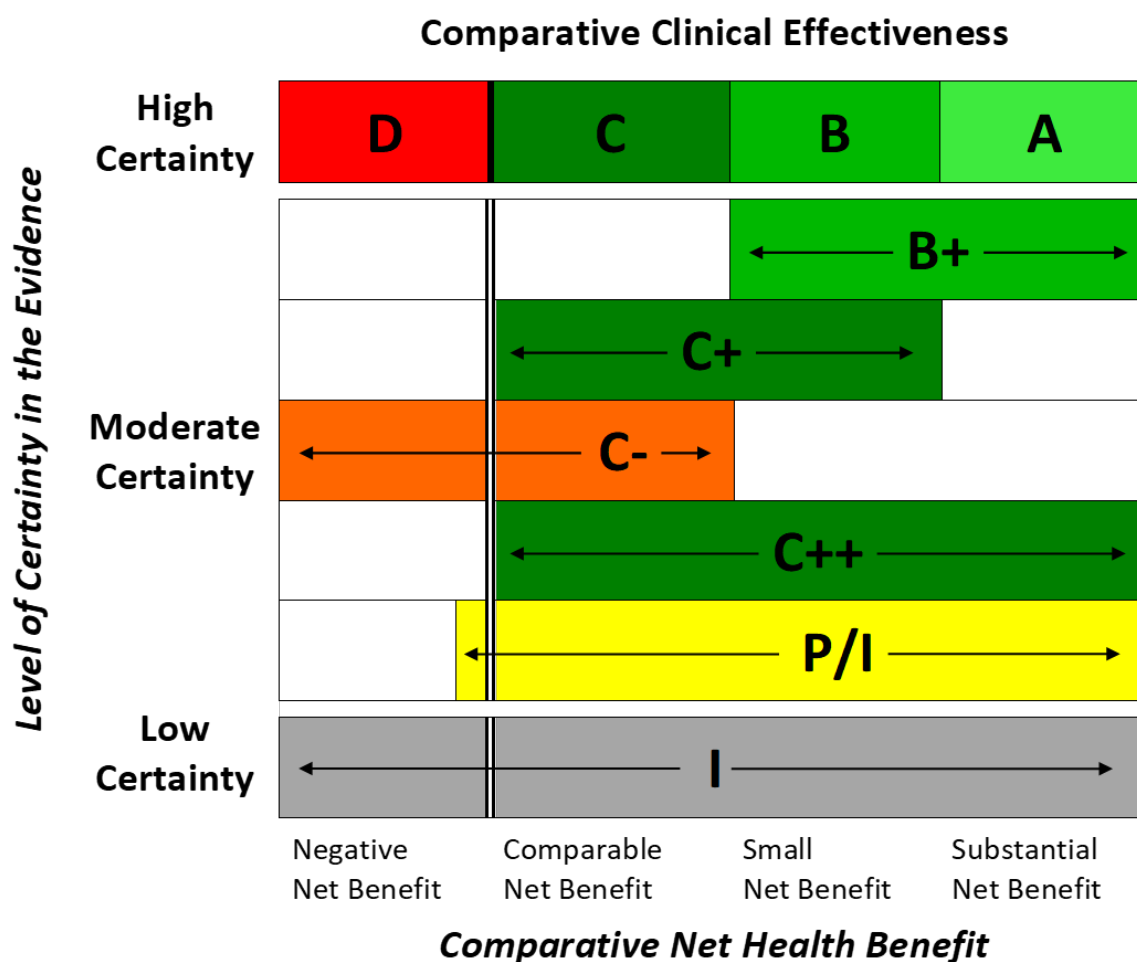
Patients treated with mavacamten who received cMRI during the trial demonstrated substantial regression in the pathological hypertrophic characteristic of this syndrome.<sup>37</sup> However, as mentioned above, symptoms of clinical dyspnea as measured by the KCCQ dropped from week 30 at the end of the trial to baseline by week 38, after eight weeks off study medication.<sup>1</sup> This discordance between 1) imaging results in the cMRI sub-study showing regression of hypertrophy and 2) patient-reported outcomes worsening after discontinuation of mavacamten raise concerns about the adequacy of imaging findings as surrogate outcomes. Furthermore, if any recurrence of hypertrophy occurs after stopping mavacamten, the clinical implication of that recurrence is unclear.



### 3.3. Summary and Comment

An explanation of the ICER Evidence Rating Matrix (Figure 3.1) is provided [here](#).

Figure 3.1. ICER Evidence Rating Matrix



**A = "Superior"** - High certainty of a substantial (moderate-large) net health benefit

**B = "Incremental"** - High certainty of a small net health benefit

**C = "Comparable"** - High certainty of a comparable net health benefit

**D = "Negative"** - High certainty of an inferior net health benefit

**B+ = "Incremental or Better"** - Moderate certainty of a small or substantial net health benefit, with high certainty of at least a small net health benefit

**C+ = "Comparable or Incremental"** - Moderate certainty of a comparable or small net health benefit, with high certainty of at least a comparable net health benefit

**C- = "Comparable or Inferior"** - Moderate certainty that the net health benefit is either comparable or inferior with high certainty of at best a comparable net health benefit

**C++ = "Comparable or Better"** - Moderate certainty of a comparable, small, or substantial net health benefit, with high certainty of at least a comparable net health benefit

**P/I = "Promising but Inconclusive"** - Moderate certainty of a small or substantial net health benefit, small (but nonzero) likelihood of a negative net health benefit

**I = "Insufficient"** - Any situation in which the level of certainty in the evidence is low



The randomized EXPLORER trial demonstrates that mavacamten improves exertional symptoms and quality of life in patients with symptomatic HOCM and had relatively few adverse effects during the trial period. This trial has reported data including patient-reported outcomes and physician-assessed outcomes, which are concordant with an objective measure of physiologic oxygen consumption. As such, EXPLORER presents a range of concordant, relevant patient outcomes with a strong study design (prospective randomized placebo-controlled trial) creating evidence for the efficacy of mavacamten. Taken alone, this information could have led to a better evidence rating. Importantly, however, with any new therapy there are concerns about adverse effects not detected during pre-approval trials. In our review, experts had starkly contrasting interpretations of the safety signals from EXPLORER. In particular, some experts worry that the reduction in LVEF and myocardial muscle thickness could lead to long-term harms rather than benefits.<sup>36</sup> Thus, in the absence of additional long-term evidence on mavacamten, we need to consider the potential for possible net harms, and we rate mavacamten in addition to usual care compared with usual care alone as *promising but inconclusive* (“P/I”).

When comparing mavacamten with disopyramide, we are limited by the absence of head-to-head randomized trials and the absence of randomized trials of disopyramide. The best observational evidence on disopyramide appears to show similar benefits to mavacamten in those who continue taking it, but the study design could inflate the benefits of disopyramide: those who did not improve on it would be more likely to discontinue therapy. Additionally, disopyramide has known common side effects from its anticholinergic effects and the potential for serious harms from being pro-arrhythmic. The long-acting form suffers from a drug shortage and in practice, few patients take disopyramide. On balance, and considering the lack of long-term evidence on mavacamten, we consider the evidence for mavacamten compared with disopyramide to be *promising but inconclusive* (“P/I”) as well.

We lack randomized trials of septal reduction therapies either to each other, compared with no procedure, or compared with mavacamten. Observational data appears to show greater improvements in functional outcomes with such procedures than was seen in the EXPLORER trial. However, these procedures carry risks of serious harms including death and the need for pacemakers to manage damage to the cardiac conduction system. Additionally, most data on these procedures comes from centers of excellence and it is uncertain how these results generalize when the procedures are done elsewhere. As discussed later in this report, modeling suggests greater quality-adjusted life year (QALY) gains with septal reduction procedures than with mavacamten. On balance, it seems likely that for patients who qualify for a septal reduction procedure, overall benefits are greater with a procedure than with mavacamten. However, this choice is highly dependent on patient preferences given the potential for short-term harms with procedures. Evidence-based medicine groups have considered that there can be rare situations in which assigning a preferred strategy is unhelpful given expected wide discrepancies in patient choices based on individual patient preferences. That is, the effects of common individual patient

preferences are so important that large variation will persist even with ideal comparative effectiveness evidence. We believe the tradeoffs between a more effective procedure for HOCM with a small but important short-term risk of death and a less effective medication are very preference dependent. Given this profound preference dependence, recommending a specific strategy is unhelpful. As such, we are not assigning an evidence rating to this comparison. These decisions will need to be made on a case-by-case basis through discussions among patients, families, and clinicians.

**Table 3.9. Evidence Ratings**

<b>Treatment</b>	<b>Comparator</b>	<b>Evidence Rating</b>
Mavacamten plus beta blockers and calcium channel blockers	Beta blockers and calcium channel blockers alone	P/I
Mavacamten plus beta blockers and calcium channel blockers	Disopyramide	P/I
Mavacamten plus beta blockers and calcium channel blockers	Septal reduction therapies	See discussion in text

P/I: promising but inconclusive

## 4. Long-Term Cost Effectiveness

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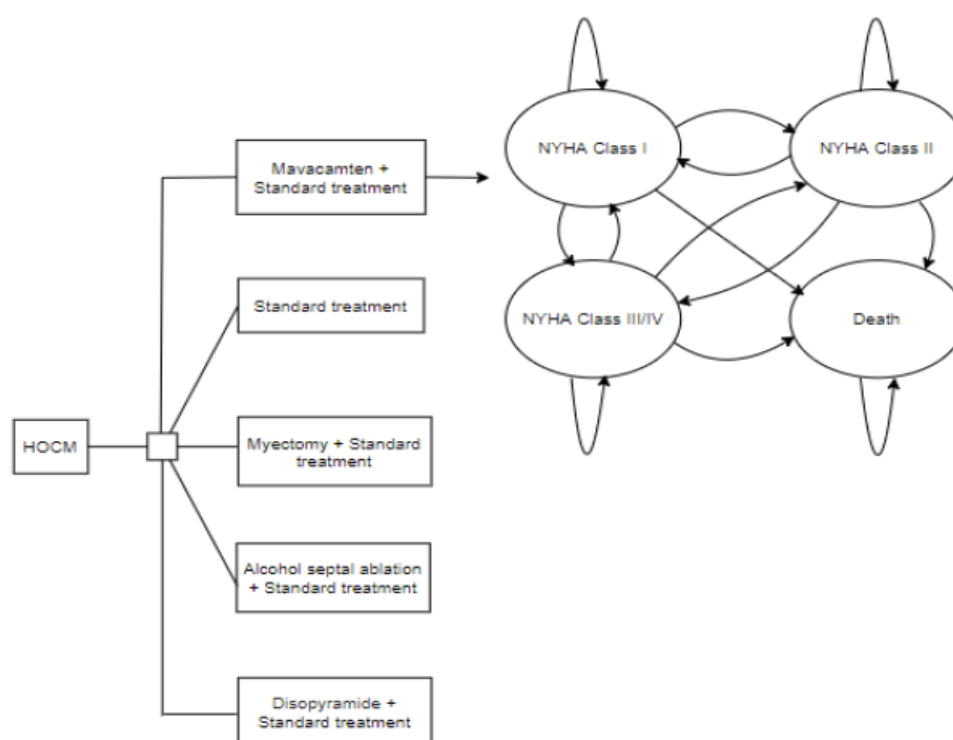
### 4.1. Methods Overview

The primary aim of this analysis was to estimate the incremental cost effectiveness of mavacamten used along with first-line standard of care treatments for patients with symptomatic HOCM. We developed a *de novo* semi-Markov model for this evaluation, informed by key clinical trials and prior relevant economic models. Costs and outcomes were discounted at 3% per year.

The model focused on an intention-to-treat analysis, with a hypothetical cohort of patients with symptomatic HOCM starting the model and being treated with mavacamten along with standard first-line therapy, standard first-line therapy alone, myectomy along with standard first-line therapy, septal ablation along with standard first-line therapy, or disopyramide along with standard first-line therapy. Model cycle length was four weeks, based on available clinical data.

Figure 4.1 shows the treatment pathways and health states that form the Markov model. The model was programmed in Microsoft Excel 2016 (Redmond, WA). Treatment effects were characterized via observed changes in NYHA class post-treatment available from clinical trial data for mavacamten and standard first-line treatment and standard first-line therapy alone. Literature-based estimates of NYHA class changes for myectomy and standard first-line therapy, septal ablation with first-line therapy, and for disopyramide and standard first-line therapy were extrapolated to be comparable to the patient population in EXPLORER (see further detail below). Proportion of alive patients across NYHA class was assumed to be constant after Cycle 8 (week 32) in the mavacamten and standard first-line therapy and standard first-line therapy alone arms and past Cycle 1 (week four) in the myectomy and standard first-line therapy, septal ablation and standard first-line therapy, and disopyramide and standard first-line therapy arms. Based on discussions with clinical experts and a literature review, mortality rates, adjusted for age and gender, reflected US average all-cause mortality from the Centers for Disease Control and Prevention (CDC) and were assumed constant across NYHA class in this model. As such, the only mortality effect across treatments in the base-case model was associated with perioperative mortality from myectomy and septal ablation. A scenario analysis was also conducted that assigned higher mortality to patients in NYHA class III/IV. Patients remained in the model until they died.

**Figure 4.1. Model Structure**



HOCM: hypertrophic obstructive cardiomyopathy, NYHA: New York Heart Association

Several changes were made in response to public comments. First, several errors were identified in the model inputs, including an incorrect disutility for age and a switch of the perioperative mortality rates for septal ablation and myectomy. We had also reported undiscounted totals of time in NYHA class I. Additional detail surrounding costs was added to the input tables. We have updated the sensitivity analyses and they are shown separately for cost and QALYs and we have added a scenario analysis mentioned above considering increased mortality associated with NYHA class III/IV. Our base-case analysis continues to take a health care sector perspective (i.e., focuses on direct medical care costs only) and uses a lifetime time horizon. Unfortunately, data to conduct a formal societal perspective analysis were not available. However, we have also added a few scenario analyses showing the impact of hypothetical employment effects of mavacamten and standard first-line therapy relative to first-line therapy alone.

## 4.2. Key Model Assumptions and Inputs

**Table 4.1. Key Model Assumptions**

Assumption	Rationale
Patient utilities were estimated via NYHA class with age decrements applied in the model using US average utilities across age.	Utilities were available by NYHA class from the EXPLORER trial but not by age, so we adjusted for age using US average differences by age.
We used a placeholder price of \$75,000 per year for mavacamten.	The only available estimate for the price of mavacamten was a projected annual cost found online.
Mortality was the same across NYHA classes.	This assumption ensured that there were no relative mortality effects of the treatments, which was consistent with conversations with clinical experts and available literature regarding mortality in general in HOCM as well as relative effects of treatments on mortality. A scenario analysis that assigned higher mortality to patients in NYHA class III/IV tested this assumption.
We used transition rates across NYHA classes for mavacamten along with standard first-line therapy and for first-line therapy, based on those seen in weeks 26-30 to project NYHA class up to Cycle 8 in the model and then held the proportion of alive patients in each NYHA class constant.	The only available data to model NYHA class transitions in HOCM patients across time for mavacamten with first-line therapy and for first-line therapy alone were from EXPLORER. There were slight upward trends in NYHA I proportions between week 26 and week 30; however, there was also reason to believe NYHA class would begin to deteriorate at some point. As a middle ground assumption, we opted to hold the proportions of alive patients fixed across NYHA classes post Cycle 8.
The treatment effect of myectomy with standard first-line therapy, septal ablation with standard first-line therapy, and disopyramide along with standard first-line therapy occurred between weeks 0-4 and then the proportions of alive patients across NYHA classes in those arms were held constant.	The data on treatment effects for myectomy with standard first-line therapy, septal ablation with standard first-line therapy, and disopyramide with standard first-line therapy were based on longer time periods, years rather than weeks, making it impossible to know how rapid the treatment effects occurred or to know particular dynamics in the treatment effect that may have occurred over the first several months/years. It is possible that the treatment effects were larger or smaller in earlier time periods following the treatment in question than what was measured. It is also likely that eventually NYHA status would deteriorate across the lifetime. As a middle ground assumption, we opted to hold the proportion of alive patients across NYHA class constant after the first cycle in those two arms.
The model did not include discontinuation or serious adverse events.	Comparable data were not available for these aspects of the treatment courses other than directly between mavacamten with first-line therapy and first-line therapy alone where the rates of adverse events were very similar. Discontinuation was considered indirectly in the disopyramide treatment effect (see below) in a way consistent with how mavacamten was being modeled in terms of projections over a lifetime based on the trial data. Discontinuation over the long term in mavacamten was not available nor the extent to which discontinuation would result in surgical options. Minor disutility differences in comparing mavacamten and first-line therapy vs. first-line therapy alone are included. Substantial relative differences in adverse events associated with the treatments were not apparent in the literature other than perioperative mortality for myectomy and septal ablation, disutility from major surgery for myectomy and septal ablation, and higher use of pacemakers with septal ablation than myectomy, which were included in the model.

HOCM: hypertrophic obstructive cardiomyopathy, NYHA: New York Heart Association, US: United States

Table 4.2 below lists selected base-case model inputs along with the lower and upper values used in the deterministic sensitivity analyses. See the [Report Supplement](#) for more detailed descriptions of the model inputs.

**Table 4.2. Model Inputs**

Input Name	Treatment	Base Case	Lower Value	Upper Value
<b>Epidemiological Inputs</b>				
Age	--	58.00	34.00	82.00
Female	--	0.41	--	--
<b>Clinical Inputs</b>				
Mavacamten Treatment Effect (% NYHA I in Cycle 1)	Mavacamten	0.24	0.18	0.31
First-Line Treatment Effect	Standard	0.08	0.06	0.10
Myectomy Treatment Effect	Myectomy	0.77	0.58	0.96
Disopyramide Treatment Effect	Disopyramide	0.28	0.21	0.36
Septal Ablation Treatment Effect	Septal ablation	0.77	0.58	0.96
<b>Quality-of-Life Inputs</b>				
Utility of NYHA Class I for Mavacamten	Mavacamten	0.95	0.65	1.00
Utility of NYHA Class II for Mavacamten	Mavacamten	0.87	0.66	0.98
Utility of NYHA Class III and IV for Mavacamten	Mavacamten	0.71	0.56	0.84
Utility of NYHA Class I for SoC	Standard	0.95	0.65	1.00
Utility of NYHA Class II for SoC	Standard	0.85	0.65	0.97
Utility of NYHA Class III and IV for SoC	Standard	0.70	0.56	0.83
Utility of NYHA Class I for Other Comparators	Myectomy, septal ablation, and disopyramide	0.95	0.65	1.00
Utility of NYHA Class II for Other Comparators	Myectomy, septal ablation, and disopyramide	0.86	0.65	0.98
Utility of NYHA Class III and IV for Other Comparators	Myectomy, septal ablation, and disopyramide	0.71	0.56	0.83
<b>Cost Inputs*</b>				
Per Cycle Cost of Mavacamten	Mavacamten	\$5,769	\$4,694	\$6,954
First Cycle Cost of Metoprolol	Metoprolol cycle 1	\$38	\$31	\$46
Per Cycle Cost of Metoprolol	Metoprolol	\$64	\$52	\$77
First Cycle Cost of Verapamil	Verapamil cycle 1	\$49	\$40	\$59
Per Cycle Cost of Verapamil	Verapamil	\$56	\$46	\$67
First Cycle Cost of Disopyramide	Disopyramide	\$309	\$252	\$373
Per Cycle Cost of Disopyramide	Disopyramide	\$413	\$336	\$497
Disopyramide Hospitalization Cost	Disopyramide	\$8,559	\$6,964	\$10,316
Myectomy Procedure Cost	Myectomy	\$122,759	\$99,881	\$147,960
Septal Ablation Procedure Cost	Septal ablation	\$55,706	\$45,325	\$67,142

NYHA: New York Heart Association, SoC: standard of care

\*All costs used in the model were updated to 2021 dollars based on the methods outlined in the [ICER Reference Case](#).

## Sensitivity and Threshold Analyses

We conducted deterministic one-way sensitivity analyses to identify the impact of parameter uncertainty and key drivers of model outcomes. Probabilistic sensitivity analyses were also performed by jointly varying all model parameters over 1,000 simulations, then calculating 95% credible range estimates for each model outcome based on the results. We also performed threshold analyses for drug costs across a range of incremental cost-effectiveness ratios (\$50,000, \$100,000, \$150,000, and \$200,000 per QALY and evLYG) for mavacamten and first-line therapy relative to first-line therapy alone.

We included a scenario analysis that incorporates higher mortality for patients in NYHA class III/IV (hazard ratio [HR] 1.96) based on a meta-analysis of HCM patients.<sup>38</sup> We also had wanted to include a formal scenario analysis from a societal perspective but were unable to acquire the necessary data. We do consider several scenario analyses to examine the impact of potential differences from a societal perspective. First, we look at mavacamten and standard first-line therapy relative to standard first-line therapy alone where we model patients in NYHA class I as working full time and those in NYHA class II and class III/IV as being unemployed. In a second related scenario, we model mavacamten patients as all being employed and have all patients on first-line therapy alone as unemployed. In each case, we use average US wages (\$27.07) across all occupations and 2,000 hours per year to model the annual financial gains for employed patients.<sup>39</sup>

## 4.3. Results

### Base-Case Results

Tables 4.3 and 4.4 below present the base-case results.

**Table 4.3. Results for the Base Case for Each of the Treatments**

Treatment	Total Drug Cost	Total Cost	QALYs	Life Years	NYHA I Years	evLY
Mavacamten*†	\$1,258,000	\$1,568,000	14.75	16.58	8.50	14.75‡
Standard Treatment	\$12,600	\$434,000	13.78	16.58	3.33	13.78
Disopyramide*	\$116,000	\$509,000	14.06	16.58	4.69	14.06
Septal Ablation*	\$67,800	\$297,000	14.97	16.40	12.49	14.97
Myectomy*	\$135,000	\$364,000	14.97	16.37	12.47	14.97

evLY: equal-value of life years, N/A: not applicable, NYHA: New York Heart Association, QALY: quality-adjusted life year

\*Each of these treatments includes use of standard first-line therapy.

†Cost estimates for mavacamten were based on a placeholder price of \$75,000 per year.

‡evLY for mavacamten is calculated as compared to standard treatment.

**Table 4.4. Incremental Cost-Effectiveness Ratios for Mavacamten in the Base Case**

Treatment	Comparator	Cost per QALY Gained	Cost per Life Year Gained	Cost per evLY Gained	Cost per Additional NYHA I Year
<b>Mavacamten*</b>	Standard treatment	\$1,200,000	Undefined	\$1,200,000	\$219,000
	Disopyramide	\$1,500,000	Undefined	\$1,500,000	\$278,000
	Myectomy	Dominated	\$5,600,000	N/A†	Dominated
	Septal ablation	Dominated	\$7,000,000	N/A†	Dominated

evLY: equal-value of life years, N/A: not applicable, NYHA: New York Heart Association, QALY: quality-adjusted life year

\*Incremental cost ratios are based on a placeholder price of \$75,000 per year for mavacamten.

†Incremental cost per evLY gained not applicable due to fewer lifetime QALYs for mavacamten as compared to myectomy and septal ablation.

In the model, mavacamten along with standard first-line therapy was projected to produce more QALYs than standard first-line therapy alone but with very high additional costs when assuming a placeholder price of \$75,000 per year for mavacamten. This resulted in an incremental cost per QALY well above standard thresholds. The incremental cost per QALY is even higher when comparing mavacamten to disopyramide. When compared to myectomy and septal ablation in terms of QALYs, mavacamten costs more and produced fewer QALYs. In terms of life years, due to procedural mortality, mavacamten produces more life years but at a very high cost per life year gained.

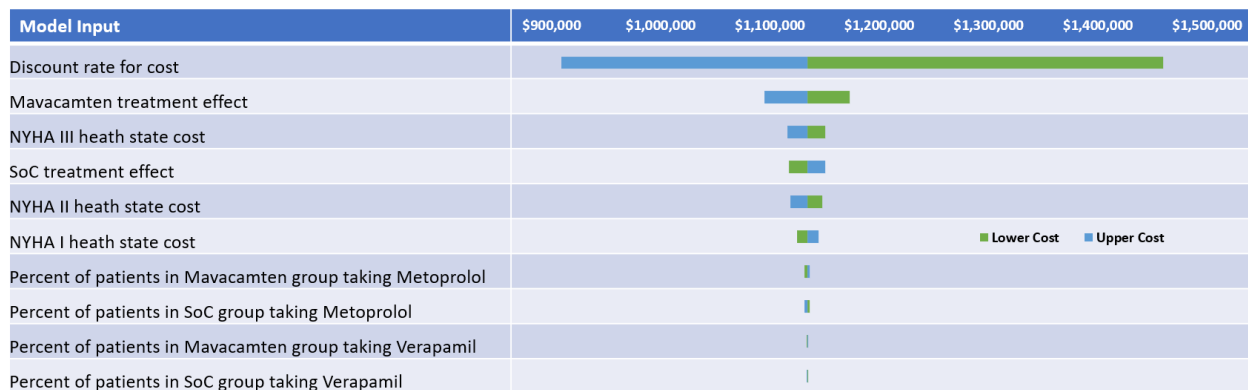
## Sensitivity Analyses

One-way sensitivity analyses were conducted to measure the effect of uncertainty on projected incremental costs and QALYs between mavacamten with first-line therapy relative to first-line therapy alone. Figures 4.2A and 4.2B and Tables 4.5A and 4.5B present the results of these deterministic sensitivity analyses. Table 4.6 presents a summary of the probabilistic sensitivity analyses comparing mavacamten to standard treatment alone.

Given the lifetime horizon model, naturally, the incremental costs were sensitive to the discount rate though always sizable. The projected incremental costs were also relatively sensitive to potential variance in the treatment effects and NYHA-class-related costs although, once again, the projected incremental costs were always sizable. The incremental QALYs were relatively sensitive to the NYHA class utilities although, overall, mavacamten ranged from negative to relatively small gains in comparison with the incremental costs. Potential variance in the treatment effects of mavacamten with first-line therapy and first-line therapy alone had lesser effects on the QALYs than the utility scores of the NYHA.



**Figure 4.2A. Tornado Diagram of Incremental Cost for Mavacamten versus Standard of Care**



NYHA: New York Heart Association, SoC: standard of care

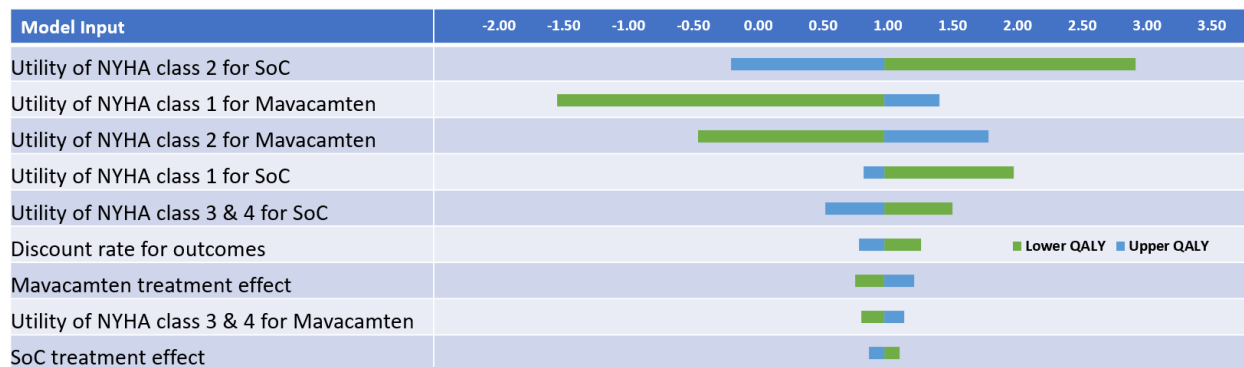
**Table 4.5A. Inputs and Results for Mavacamten versus Standard of Care Incremental Cost Tornado Diagram**

Input	Lower Cost	Upper Cost	Low-Input Value	High-Input Value
Discount Rate for Cost	\$1,459,478	\$909,141	0.01	0.05
Mavacamten Treatment Effect	\$1,172,786	\$1,094,769	0.18	0.31
NYHA III Heath State Cost	\$1,150,089	\$1,115,809	\$2,299.24	\$3,405.99
SoC Treatment Effect	\$1,117,467	\$1,150,088	0.06	0.10
NYHA II Heath State Cost	\$1,147,666	\$1,118,478	\$1,663.84	\$2,464.74
NYHA I Heath State Cost	\$1,124,338	\$1,144,176	\$611.31	\$905.57
Percent of Patients in Mavacamten Group Taking Metoprolol	\$1,131,167	\$1,136,388	0.57	0.95
Percent of Patients in SoC Group Taking Metoprolol	\$1,136,319	\$1,131,236	0.56	0.93
Percent of Patients in Mavacamten Group Taking Verapamil	\$1,133,174	\$1,134,381	0.15	0.25
Percent of Patients in SoC Group Taking Verapamil	\$1,134,170	\$1,133,385	0.10	0.16

NYHA: New York Heart Association, SoC: standard of care

\*Note lower input may reflect either upper or lower ICER value depending on the direction that the input has on the ICER output.

**Figure 4.2B. Tornado Diagram of Incremental QALY for Mavacamten versus Standard of Care**



NYHA: New York Heart Association, SoC: standard of care

**Table 4.5B. Inputs and Results for Mavacamten versus Standard of Care Incremental QALY Tornado Diagram**

Input	Lower QALY	Upper QALY	Low-Input Value	High-Input Value
Utility of NYHA Class II for SoC	2.91	-0.21	0.65	0.97
Utility of NYHA Class I for Mavacamten	-1.55	1.40	0.65	1.00
Utility of NYHA Class II for Mavacamten	-0.47	1.78	0.66	0.98
Utility of NYHA Class I for SoC	1.98	0.81	0.65	1.00
Utility of NYHA Class III and IV for SoC	1.50	0.52	0.56	0.83
Discount Rate for Outcomes	1.26	0.78	0.01	0.05
Mavacamten Treatment Effect	0.75	1.20	0.18	0.31
Utility of NYHA Class III and IV for Mavacamten	0.80	1.13	0.56	0.84
SoC Treatment Effect	1.09	0.86	0.06	0.10

NYHA: New York Heart Association, QALY: quality-adjusted life year, SoC: standard of care

Tables 4.6A and 4.6B below show the results of the probabilistic sensitivity analysis. The table illustrates that extremely few and/or none of the simulations resulted in mavacamten along with first-line treatment being deemed cost effective relative to first-line therapy alone even at a willingness-to-pay threshold of \$200,000 per QALY. The results were the same in looking at costs per evLYG.

**Table 4.6A. Probabilistic Sensitivity Analysis Cost per QALY Gained Results: Mavacamten versus Standard of Care**

	Cost Effective at \$50,000 per QALY	Cost Effective at \$100,000 per QALY	Cost Effective at \$150,000 per QALY	Cost Effective at \$200,000 per QALY
Mavacamten	0.0%	0.0%	0.0%	0.0%

QALY: quality-adjusted life year

**Table 4.6B. Probabilistic Sensitivity Analysis Cost per evLYG Gained Results: Mavacamten versus Standard of Care**

	Cost Effective at \$50,000 per evLYG	Cost Effective at \$100,000 per evLYG	Cost Effective at \$150,000 per evLYG	Cost Effective at \$200,000 per evLYG
<b>Mavacamten</b>	0.0%	0.0%	0.0%	0.0%

evLYG: equal value of life years gained

## Scenario Analyses

Tables 4.7 and 4.8 below show the incremental results when higher mortality for NYHA class III/IV is incorporated into the model. Again, we find that mavacamten plus standard of care had high incremental cost utility ratios relative to standard of care and to disopyramide plus standard of care and that it was dominated by the other arms

**Table 4.7. Results for the Scenario with Higher Mortality for NYHA Class III/IV**

Intervention	Intervention Costs	Total Costs	QALYs	Life Years	NYHA I Years	evLY
<b>Mavacamten</b>	\$1,242,000	\$1,544,000	14.60	16.37	8.49	14.97
<b>Standard Treatment</b>	\$12,100	\$410,000	13.33	15.94	3.32	13.33
<b>Disopyramide</b>	\$112,000	\$485,000	13.68	16.04	4.69	13.68
<b>Septal Ablation</b>	\$67,700	\$295,000	14.92	16.33	12.49	14.88
<b>Myectomy</b>	\$135,000	\$361,000	14.92	16.30	12.47	14.89

evLY: equal value of life years, NYHA: New York Heart Association, QALY: quality-adjusted life year

**Table 4.8. Incremental Cost-Effectiveness Ratios for Mavacamten in the Scenario with Higher Mortality for NYHA Class III/IV**

Treatment	Comparator	Cost per QALY Gained	Cost per Life Year Gained	Cost per evLY Gained	Cost per Additional NYHA I Year
<b>Mavacamten</b>	Standard treatment	\$893,000	\$2,600,000	\$693,000	\$219,000
	Disopyramide	\$1,100,000	\$3,100,000	\$874,000	\$279,000
	Myectomy	Dominated	\$15,800,000	N/A*	Dominated
	Septal ablation	Dominated	\$29,900,000	N/A*	Dominated

evLY: equal value of life years, N/A: not applicable, NYHA: New York Heart Association, QALY: quality-adjusted life year

\*Incremental cost per evLY gained not applicable due to fewer lifetime QALYs for mavacamten as compared to myectomy and septal ablation.

Table 4.9 below presents the incremental results of mavacamten and first-line therapy versus first-line therapy alone for the case when NYHA class I was associated with full employment and NYHA class II and III/IV were associated with no employment and also for an even more extreme case where mavacamten was associated with full employment in all NYHA classes and standard first-line therapy was associated with zero employment. In both, the incremental costs for QALYs remain above standard thresholds.

**Table 4.9. Societal-Perspective-Related Scenario Analysis**

Scenario	Cost per QALY Gained	Cost per Life Year Gained	Cost per evLY Gained	Cost per Additional NYHA I Year
Full Employment for NYHA I and Not for Class II and III/IV (Both Mavacamten and Standard Treatment Group)	\$876,000	N/A	\$876,000	\$165,000
Full Employment for All Patients in Mavacamten Group and Not for Standard Treatment Group	\$242,000	N/A	\$242,000	\$46,000

evLY: equal value of life years, N/A: not applicable, NYHA: New York Heart Association, QALY: quality-adjusted life year

## Threshold Analyses

Tables 4.10A and 4.10B show per-year threshold costs for mavacamten that would be needed to achieve willingness-to-pay thresholds per QALY and per evLYG of \$50,000, \$100,000, \$150,000, and \$200,000.

**Table 4.10A. QALY-Based Threshold Analysis Results**

	Placeholder Cost	Price to Achieve \$50,000 per QALY	Price to Achieve \$100,000 per QALY	Price to Achieve \$150,000 per QALY	Price to Achieve \$200,000 per QALY
Mavacamten	\$75,000	\$9,600	\$12,500	\$15,400	\$18,400

QALY: quality-adjusted life year

**Table 4.10B. evLYG-Based Threshold Analysis Results**

	Placeholder Cost	Price to Achieve \$50,000 per evLYG	Price to Achieve \$100,000 per evLYG	Price to Achieve \$150,000 per evLYG	Price to Achieve \$200,000 per evLYG
Mavacamten	\$75,000	\$9,600	\$12,500	\$15,400	\$18,400

evLY: equal value of life years gained

## Model Validation

We used several approaches to validate the model. First, we provided the preliminary model structure, methods, and assumptions to the manufacturer, patient organizations, and clinical experts. Based on feedback from these groups, we refined the data inputs used in the model, as needed. Second, we varied model input parameters to evaluate the face validity of changes in results. We also performed model verification for model calculations using internal reviewers. As part of ICER's efforts in acknowledging modeling transparency, we also shared the model with Bristol Myers Squibb for external verification around the time of publishing the draft Evidence Report for this review. The model was also subjected to several internal checks for logical functioning by changing the inputs and also several reviews of the inputs for accuracy.

## Uncertainty and Controversies

There were only 30 weeks of data available for mavacamten in the EXPLORER trial on which to base projected treatment effects by NYHA class, and the EXPLORER data may not generalize to other patient populations. The utilities in the model across NYHA class also come from the trial and may not generalize to other HOCM patients. However, they were derived from HOCM patients, which we deemed to be an improvement over using utilities from more general heart failure populations. In addition, there were multiple comparators but not sufficient data to conduct a network meta-analysis or other quantitative analyses controlling for treatment effects across baseline characteristics of patients in forming estimates for the comparators such as myectomy, septal ablation, and disopyramide relative to mavacamten. Further, the evidence for myectomy, septal ablation, and disopyramide comes from observational studies while the evidence for mavacamten and standard first-line therapy used in the modeling came from the EXPLORER trial.

The modeling of the treatment arms did not include discontinuation and subsequent use of other options. Though it is beyond the scope of this analysis, it is possible that greater or smaller proportions of patients on mavacamten may elect to have myectomy or septal ablation in the future as compared to standard first-line treatment alone and/or disopyramide along with standard first-line treatments. In terms of cost effectiveness, the procedures were dominant to mavacamten to begin with, but if mavacamten plus standard first-line therapy was associated with fewer follow-up procedures than standard first-line treatments alone that could impact the cost effectiveness of mavacamten and first-line therapy relative to first-line therapy alone. In addition, some of the mavacamten patients in the EXPLORER trial had previously undergone septal reduction procedures, which was not included in the model. Further, the procedural options involve tradeoffs between short-term mortality and long-term expected gains in QALYs that are not present in the pharmaceutical-only options.

Also, we were not able to include a societal perspective analysis using actual data. However, we did present several scenarios based on hypothetical data. Even under extreme assumptions, mavacamten was not beneath commonly-cited thresholds from this hypothetical extreme societal perspective assuming the placeholder price for mavacamten. Further, we conducted the two additional scenario analyses to examine the impact of having treatment associated with employment.

Finally, available non-drug cost estimates by NYHA class are for a private payer and/or based on data from heart failure patients and we only had access to a placeholder cost for mavacamten.

## 4.4. Summary and Comment

Mavacamten used along with standard first-line treatment was projected to generate higher amounts of QALYs than standard first-line treatment alone. However, at the placeholder cost of \$75,000, the incremental cost-effectiveness ratios were well above standard thresholds. When compared with disopyramide, the incremental cost per QALY was even higher, and mavacamten was found to be dominated by both myectomy and septal ablation. The sensitivity and scenario analyses suggested, using the placeholder price, that these findings were robust. However, the actual cost effectiveness of mavacamten will depend on its price.

## 5. Contextual Considerations and Potential Other Benefits

Our reviews seek to provide information on potential other benefits offered by the intervention to the individual patient, caregivers, the delivery system, other patients, or the public that was not available in the evidence base nor could be adequately estimated within the cost-effectiveness model. These elements are listed in the tables below, with related information gathered from patients and other stakeholders. Following the public deliberation on this report the appraisal committee will vote on the degree to which each of these factors should affect overall judgments of long-term value for money of the intervention(s) in this review.

**Table 5.1. Contextual Considerations**

Contextual Consideration	Relevant Information
Acuity of need for treatment of individual patients based on short-term risk of death or progression to permanent disability	For many patients with symptomatic HOCM, the burden of disease can be very severe. In addition to exertional symptoms and the risk of sudden cardiac death, patients with HOCM also face anxiety, depression, concerns about activities of daily living and social events. There is uncertainty about the extent to which exercise can increase risk of sudden cardiac death for HOCM patients, and guidelines have shifted over time, leading to uncertainty and confusion among HOCM patients about optimal self-care. Since patients often have electrocardiograms and echocardiograms that mimic other conditions, including acute myocardial infarction and hypertensive heart disease, misdiagnosis is common and patients with HCM and HOCM often have frustrations with the health care system.
Magnitude of the lifetime impact on individual patients of the condition being treated	<p>Patients with symptomatic HOCM are often at points in their lives when they are making important life choices regarding education, work, and raising families, which could provide benefits over and above the improvement in QALYs calculated in the model.</p> <p>The fear of death given the potential of malignant ventricular arrhythmias is often present throughout life, causing a large burden to patients. Patients also report lifelong grief related to life decisions made because of fear of HCM-related complications.</p>

HCM: hypertrophic cardiomyopathy, HOCM: hypertrophic obstructive cardiomyopathy, QALY: quality-adjusted life year

**Table 5.2. Potential Other Benefits or Disadvantages**

Potential Other Benefit or Disadvantage	Relevant Information
Patients' ability to achieve major life goals related to education, work, or family life	<p>Particularly when patients are diagnosed early in life, uncertainty and fear can lead to pressured life decisions about educational programs, marriage and relationships, and decisions about whether to have children. Patients reported concern about passing along genes associated with HCM to children. Some of those concerns about children are related to lack of treatment options for symptoms.</p> <p>Patients themselves are often underemployed because they fear moving to new jobs or communities because these moves could disrupt insurance, social supports, and access to caregivers.</p> <p>Symptoms of HCM or arrhythmias related to HCM can interfere with work or social activities, affecting both career advancement and relationships.</p>
Caregivers' quality of life and/or ability to achieve major life goals related to education, work, or family life	<p>Patients also reported that the diagnosis of HCM can lead to difficulties receiving life insurance, being admitted to educational programs, and receiving loans. This can lead to underemployment since patients are reluctant to switch jobs, which often creates a shift in insurance policy.</p> <p>When caregivers are needed to provide care for HCM patients, they sometimes cannot work, exacerbating financial problems.</p>
Patients' ability to manage and sustain treatment given the complexity of regimen	<p>Many patients who experience side effects or insufficient relief from beta blockers and calcium channel blockers have difficulty with accessing disopyramide, given national drug shortages of the long-acting version. The short-acting version of disopyramide can provide inconsistent relief of symptoms throughout the day.</p>
Society's goal of reducing health inequities	<p>Mavacamten could provide more access to treatment options because septal reduction procedures are only available at specialized centers in specific cities.</p>

HCM: hypertrophic cardiomyopathy, HOCM: hypertrophic obstructive cardiomyopathy



## 6. Health-Benefit Price Benchmarks

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Health benefit price benchmarks (HBPBs) for the annual cost of treatment are presented in Table 6.1 below. The HBPB for a drug is defined as the drug price range that would achieve incremental cost-effectiveness ratios between \$100,000 and \$150,000 per QALY gained or per evLYG. For mavacamten, this range is \$12,000 to \$15,000 annually.

**Table 6.1. Annual Health Benefit Price Benchmarks for Mavacamten**

	Annual Price at \$100,000 Threshold	Annual Price at \$150,000 Threshold
<b>QALYs Gained</b>	\$12,000	\$15,000
<b>evLYG</b>	\$12,000	\$15,000

evLYG: equal value of life years gained, QALY: quality-adjusted life year

## 7. Potential Budget Impact

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### 7.1. Overview of Key Assumptions

Using results from the cost-effectiveness model, we estimated the potential budgetary impact of mavacamten for patients with symptomatic HOCM. We used the mavacamten price from the base-case analysis (placeholder price of \$75,000 per year) and three annual threshold prices (at \$50,000, \$100,000, and \$150,000 per QALY). Potential budget impact is defined as the total differential cost of using each new therapy rather than the relevant existing therapy for the treated population, calculated as differential health care costs (including intervention costs) minus any offsets in these costs from averted health care events. All costs were undiscounted and estimated over a five-year time horizon.

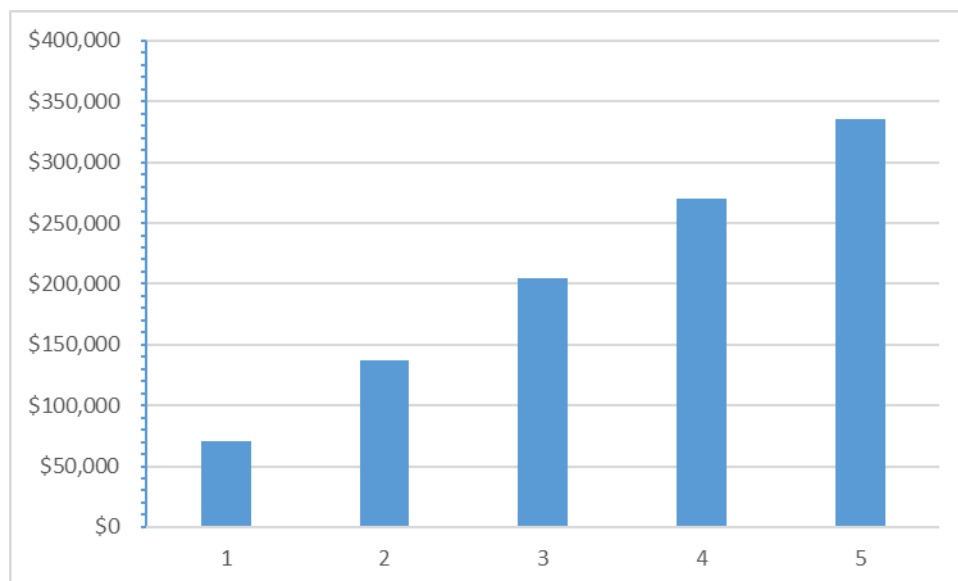
The analysis included the estimated number of individuals in the US who would be eligible for mavacamten. To estimate the size of the potential candidate population for treatment, we used inputs from best-available evidence. A study published in 2016 that examined a large claims database to calculate the prevalence of clinically-recognized HCM reported that diagnosed HCM occurred in one in 3,195 (i.e., 3.1 in 10,000) adult patients in the US.<sup>40</sup> Other literature has suggested that 70% of HCM patients have obstructive disease.<sup>41</sup> Applying these sources results in estimates of 2.2 in 10,000 patients who are diagnosed with symptomatic HOCM, or approximately 72,300 eligible patients in the US. For the purposes of this analysis, we assumed that 20% of these patients would initiate treatment in each of the five years, or approximately 14,460 patients per year. In this potential budget impact analysis, we assumed that patients eligible for mavacamten would otherwise have been treated with standard treatment.

The aim of the potential budgetary impact analysis is to document the percentage of patients who could be treated at selected prices within five years without crossing a potential budget impact threshold that is aligned with overall growth in the US economy. For 2021-2022, the five-year annualized potential budget impact threshold that should trigger policy actions to manage access and affordability is calculated to be approximately \$734 million per year for new drugs.

## 7.2. Results

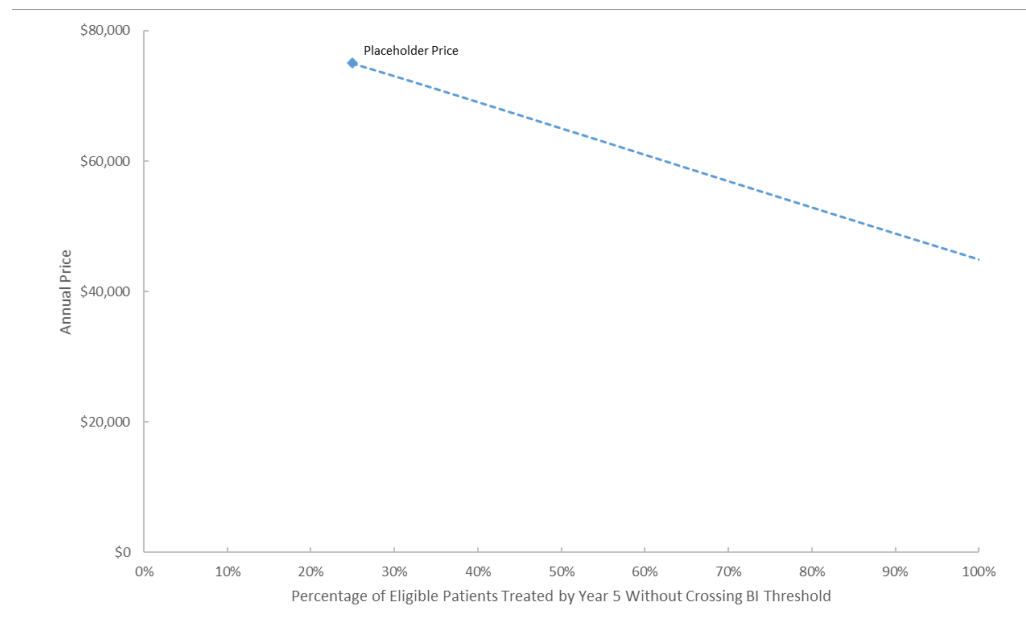
Figure 7.1 depicts the cumulative per-patient potential budget impact calculations for mavacamten as compared to standard therapy, based on a placeholder cost for mavacamten of \$75,000 per year. The average potential budgetary impact for mavacamten was approximately \$70,000 in year one, with cumulative net cost increasing each year to reach approximately \$336,000 in year five.

**Figure 7.1. Cumulative Net Cost per Patient Treatment with Mavacamten at Placeholder Price**



Assuming the placeholder price of \$75,000 per year, only 25% of the eligible patients could be treated within five years (assuming 20% uptake each year), before crossing the ICER potential budget impact threshold of \$734 million per year. All eligible patients could be treated within five years without crossing the ICER potential budget impact threshold at the price to reach either \$50,000/QALY, \$100,000/QALY, or \$150,000/QALY. Figure 7.2 depicts the potential budgetary impact of mavacamten.

**Figure 7.2. Potential Budgetary Impact of Mavacamten in Symptomatic HOCM**



BI: budget impact

# References

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1. Spertus JA, Fine JT, Elliott P, et al. Mavacamten for treatment of symptomatic obstructive hypertrophic cardiomyopathy (EXPLORER-HCM): health status analysis of a randomised, double-blind, placebo-controlled, phase 3 trial. *The Lancet*. 2021.
2. Kim LK, Swaminathan RV, Looser P, et al. Hospital Volume Outcomes After Septal Myectomy and Alcohol Septal Ablation for Treatment of Obstructive Hypertrophic Cardiomyopathy: US Nationwide Inpatient Database, 2003-2011. *JAMA Cardiology*. 2016;1(3):324-332.
3. Neubauer S, Kolm P, Ho CY, et al. Distinct Subgroups in Hypertrophic Cardiomyopathy in the NHLBI HCM Registry. *Journal of the American College of Cardiology*. 2019;74(19):2333-2345.
4. Olivetto I, Cecchi F, Casey SA, Dolara A, Traverse JH, Maron BJ. Impact of Atrial Fibrillation on the Clinical Course of Hypertrophic Cardiomyopathy. *Circulation*. 2001;104(21):2517-2524.
5. Toepfer CN, Garfinkel AC, Venturini G, et al. Myosin Sequestration Regulates Sarcomere Function, Cardiomyocyte Energetics, and Metabolism, Informing the Pathogenesis of Hypertrophic Cardiomyopathy. *Circulation*. 2020;141(10):828-842.
6. Ingles J, Burns C, Barratt A, Semsarian C. Application of Genetic Testing in Hypertrophic Cardiomyopathy for Preclinical Disease Detection. *Circulation: Cardiovascular Genetics*. 2015;8(6):852-859.
7. Maron BJ, Gardin JM, Flack JM, Gidding SS, Kurosaki TT, Bild DE. Prevalence of Hypertrophic Cardiomyopathy in a General Population of Young Adults. *Circulation*. 1995;92(4):785-789.
8. Massera D, McClelland RL, Ambale-Venkatesh B, et al. Prevalence of Unexplained Left Ventricular Hypertrophy by Cardiac Magnetic Resonance Imaging in MESA. *Journal of the American Heart Association*. 2019;8(8):e012250.
9. Ommen SR, Mital S, Burke MA, et al. 2020 AHA/ACC Guideline for the Diagnosis and Treatment of Patients With Hypertrophic Cardiomyopathy: Executive Summary. *Circulation*. 2020;142(25):e533-e557.
10. Maron BJ, Rowin EJ, Maron MS. Paradigm of Sudden Death Prevention in Hypertrophic Cardiomyopathy. *Circulation Research*. 2019;125(4):370-378.
11. Fifer MA, Vlahakes GJ. Management of Symptoms in Hypertrophic Cardiomyopathy. *Circulation*. 2008;117(3):429-439.
12. Green EM, Wakimoto H, Anderson RL, et al. A small-molecule inhibitor of sarcomere contractility suppresses hypertrophic cardiomyopathy in mice. *Science (New York, NY)*. 2016;351(6273):617-621.
13. Ommen SR, Mital S, Burke MA, et al. 2020 AHA/ACC Guideline for the Diagnosis and Treatment of Patients With Hypertrophic Cardiomyopathy. *Circulation*. 2020;142(25):e558-e631.
14. Desai MY, Wolski K, Owens A, et al. Study design and rationale of VALOR-HCM: evaluation of mavacamten in adults with symptomatic obstructive hypertrophic cardiomyopathy who are eligible for septal reduction therapy. *American Heart Journal*. 2021;239:80-89.
15. Ho CY, Mealiffe ME, Bach RG, et al. Evaluation of Mavacamten in Symptomatic Patients With Nonobstructive Hypertrophic Cardiomyopathy. *Journal of the American College of Cardiology*. 2020;75(21):2649-2660.
16. Lueder TG, Wang BH, Kompa AR, et al. Angiotensin Receptor Neprilysin Inhibitor LCZ696 Attenuates Cardiac Remodeling and Dysfunction After Myocardial Infarction by Reducing Cardiac Fibrosis and Hypertrophy. *Circ*. 2015;8(1):71-78.

17. Tafelmeier M, Baessler A, Wagner S, et al. Design of the SILICOFCM study: Effect of sacubitril/valsartan vs lifestyle intervention on functional capacity in patients with hypertrophic cardiomyopathy. *Clinical Cardiology*. 2020;43(5):430-440.
18. Cytokinetics. Sarcomere Directed Therapies. 2021.
19. Maron BJ, Casey SA, Poliac LC, Gohman TE, Almquist AK, Aeppli DM. Clinical course of hypertrophic cardiomyopathy in a regional United States cohort. *Jama*. 1999;281(7):650-655.
20. Jain SS, Li SS, Xie J, et al. CLINICAL AND ECONOMIC BURDEN OF OBSTRUCTIVE HYPERTROPHIC CARDIOMYOPATHY IN THE UNITED STATES. *Journal of the American College of Cardiology*. 2021;77(18\_Supplement\_1):668-668.
21. (HCMA) HCA. The Voice of the Patient Report for Hypertrophic Cardiomyopathy (HCM). <https://4hcm.org/wp-content/uploads/2021/06/Voice-of-the-HCM-patient-Report-final-January-9-2021.pdf>. Published 2021. Accessed 05/02/2021, 2021.
22. Eberly LA, Day SM, Ashley EA, et al. Association of Race With Disease Expression and Clinical Outcomes Among Patients With Hypertrophic Cardiomyopathy. *JAMA Cardiology*. 2020;5(1):83-91.
23. Rowin EJ, Maron MS, Wells S, Patel PP, Koethe BC, Maron BJ. Impact of Sex on Clinical Course and Survival in the Contemporary Treatment Era for Hypertrophic Cardiomyopathy. *J Am Heart Assoc*. 2019;8(21):e012041.
24. Olivotto I, Oreziak A, Barriales-Villa R, et al. Mavacamten for treatment of symptomatic obstructive hypertrophic cardiomyopathy (EXPLORER-HCM): a randomised, double-blind, placebo-controlled, phase 3 trial. *The Lancet*. 2020;396(10253):759-769.
25. Clinicaltrials.gov. Clinical Study to Evaluate Mavacamten (MYK-461) in Adults With Symptomatic Obstructive Hypertrophic Cardiomyopathy (EXPLORER-HCM). <https://clinicaltrials.gov/ct2/show/NCT03470545>. Published 2018. Accessed June 25, 2021, 2021.
26. Ho CY, Olivotto I, Jacoby D, et al. Study Design and Rationale of EXPLORER-HCM: Evaluation of Mavacamten in Adults With Symptomatic Obstructive Hypertrophic Cardiomyopathy. *Circ*. 2020;13(6):e006853.
27. Rader F, Choudhury L, Saberi S, et al. LONG-TERM SAFETY OF MAVACAMTEN IN PATIENTS WITH OBSTRUCTIVE HYPERTROPHIC CARDIOMYOPATHY: INTERIM RESULTS OF THE MAVA-LONG TERM EXTENSION (LTE) STUDY. *Journal of the American College of Cardiology*. 2021;77(18):532.
28. Olivotto I, Oreziak A, Barriales-Villa R, et al. Mavacamten for treatment of symptomatic obstructive hypertrophic cardiomyopathy (EXPLORER-HCM): a randomised, double-blind, placebo-controlled, phase 3 trial. *Lancet*. 2020;396(10253):759-769.
29. Sherri MV, Barac I, McKenna WJ, et al. Multicenter study of the efficacy and safety of disopyramide in obstructive hypertrophic cardiomyopathy. *Journal of the American College of Cardiology*. 2005;45(8):1251-1258.
30. Liebrechts M, Vriesendorp PA, Mahmoodi BK, Schinkel AFL, Michels M, ten Berg JM. A Systematic Review and Meta-Analysis of Long-Term Outcomes After Septal Reduction Therapy in Patients With Hypertrophic Cardiomyopathy. *JACC: Heart Failure*. 2015;3(11):896-905.
31. Green EM, Wakimoto H, Anderson RL, et al. A small-molecule inhibitor of sarcomere contractility suppresses hypertrophic cardiomyopathy in mice. *Science*. 2016;351(6273):617-621.
32. Butler J, Khan MS, Mori C, et al. Minimal clinically important difference in quality of life scores for patients with heart failure and reduced ejection fraction. *Eur J Heart Fail*. 2020;22(6):999-1005.

33. Bytçi I, Nistri S, Mörner S, Henein MY. Alcohol Septal Ablation versus Septal Myectomy Treatment of Obstructive Hypertrophic Cardiomyopathy: A Systematic Review and Meta-Analysis. *Journal of Clinical Medicine*. 2020;9(10):3062.
34. MyoKardia. May 11, 2020 Investor Call: EXPLORER-HCM Topline Data. 2020.
35. Adler A, Fourey D, Weissler-Snir A, et al. Safety of Outpatient Initiation of Disopyramide for Obstructive Hypertrophic Cardiomyopathy Patients. *J Am Heart Assoc*. 2017;6(6).
36. Maron MS, Ommen SR. Exploring New and Old Therapies for Obstructive Hypertrophic Cardiomyopathy: Mavacamten in Perspective. *Circulation*. 2021;143(12):1181-1183.
37. Saberi S, Cardim N, Yamani M, et al. Mavacamten Favorably Impacts Cardiac Structure in Obstructive Hypertrophic Cardiomyopathy. *Circulation*. 2021;143(6):606-608.
38. Liu Q, Li DD, Berger AE, Johns RA, Gao L. Survival and prognostic factors in hypertrophic cardiomyopathy: a meta-analysis. *Sci Rep-Uk*. 2017;7.
39. Occupational Employment and Wage Statistics. US Department of Labor; 2020. Accessed 9/30/21.
40. Maron MS, Hellawell JL, Lucove JC, Farzaneh-Far R, Olivotto I. Occurrence of Clinically Diagnosed Hypertrophic Cardiomyopathy in the United States. *The American Journal of Cardiology*. 2016;117(10):1651-1654.
41. Maron MS, Olivotto I, Zenovich AG, et al. Hypertrophic cardiomyopathy is predominantly a disease of left ventricular outflow tract obstruction. *Circulation*. 2006;114(21):2232-2239.
42. Goldman L, Hashimoto B, Cook EF, Loscalzo A. Comparative reproducibility and validity of systems for assessing cardiovascular functional class: advantages of a new specific activity scale. *Circulation*. 1981;64(6):1227-1234.
43. Ross R, Blair SN, Arena R, et al. Importance of Assessing Cardiorespiratory Fitness in Clinical Practice: A Case for Fitness as a Clinical Vital Sign: A Scientific Statement From the American Heart Association. *Circulation*. 2016;134(24):e653-e699.
44. Elliott PM, Anastakis A, Borger MA, et al. 2014 ESC Guidelines on diagnosis and management of hypertrophic cardiomyopathy: The Task Force for the Diagnosis and Management of Hypertrophic Cardiomyopathy of the European Society of Cardiology (ESC). *European Heart Journal*. 2014;35(39):2733-2779.
45. (NICE) NIfHaCE. *Non-surgical reduction of the myocardial septum*. 2004.
46. Wild C. Perkutane transluminale septale Myokardablation/PTSMA bei PatientInnen mit hyperthrophobstruktiver Kardiomyopathie. 2013.
47. Moher D, Liberati A, Tetzlaff J, Altman DG, The PG. Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLOS Medicine*. 2009;6(7):e1000097.
48. Agency for Healthcare Research and Quality. U.S. Preventive Services Task Force Procedure Manual. Published 2008. Accessed.
49. Ollendorf DA, Pearson SD. An integrated evidence rating to frame comparative effectiveness assessments for decision makers. *Medical care*. 2010;48(6 Suppl):S145-152.
50. Ollendorf D, Pearson, SD. ICER Evidence Rating Matrix: A User's Guide. <https://icer-review.org/methodology/icers-methods/icer-evidence-ratingmatrix/>. . Published 2020. Updated January 31, 2020. Accessed.
51. Heitner SB, Jacoby D, Lester SJ, et al. Mavacamten treatment for obstructive hypertrophic cardiomyopathy a clinical trial. *Annals of Internal Medicine*. 2019;170(11):741-748.
52. Clinicaltrials.gov. A Phase 2 Open-label Pilot Study Evaluating MYK-461 in Subjects With Symptomatic Hypertrophic Cardiomyopathy and Left Ventricular Outflow Tract Obstruction (PIONEER-HCM). Published 2020. Accessed.

53. Clinicaltrials.gov. A Phase 2 Study of Mavacamten in Adults With Symptomatic Non-Obstructive Hypertrophic Cardiomyopathy (nHCM) (MAVERICK-HCM). Published 2020. Accessed.
54. Haruki S, Minami Y, Suzuki A, Hagiwara N. Effects of flecainide on left ventricular pressure gradient and symptoms in obstructive hypertrophic cardiomyopathy: a comparison of flecainide and disopyramide. *Heart and Vessels*. 2015;30(5):604-610.
55. Sherrid MV, Shetty A, Winson G, et al. Treatment of Obstructive Hypertrophic Cardiomyopathy Symptoms and Gradient Resistant to First-Line Therapy With  $\beta$ -Blockade or Verapamil. *Circ*. 2013;6(4):694-702.
56. Osman M, Kheiri B, Osman K, et al. Alcohol septal ablation vs myectomy for symptomatic hypertrophic obstructive cardiomyopathy: Systematic review and meta-analysis. *Clinical Cardiology*. 2019;42(1):190-197.
57. Sherrid MV, Shetty A, Winson G, et al. Treatment of obstructive hypertrophic cardiomyopathy symptoms and gradient resistant to first-line therapy with  $\beta$ -blockade or verapamil. *Circ Heart Fail*. 2013;6(4):694-702.
58. MyoKardia. Pioneering Precision Cardiovascular Medicine: MyoKardia PIONEER-HCM Data Summary March 2018. 2018.
59. Heitner SB, Lester S, Wang A, et al. Precision pharmacological treatment for obstructive hypertrophic cardiomyopathy with mavacamten: One-year results from pioneer-ole. *Circulation*. 2019;140.
60. MyoKardia. March 4, 2019 Investor Call - PIONEER-OLE 12- and 24- Week Results. 2019.
61. Sanders GD, Neumann PJ, Basu A, et al. Recommendations for Conduct, Methodological Practices, and Reporting of Cost-effectiveness Analyses: Second Panel on Cost-Effectiveness in Health and Medicine. *Jama*. 2016;316(10):1093-1103.
62. Jiang M, You JHS. Cost-effectiveness analysis of 30-month vs 12-month dual antiplatelet therapy with clopidogrel and aspirin after drug-eluting stents in patients with acute coronary syndrome. *Clin Cardiol*. 2017;40(10):789-796.
63. M Butzner PS, M Maron, E Rowin, CC Teng, E Stanek, H Tan, L Robertson. PCV35 Costs of Septal Reduction Therapy for Obstructive Hypertrophic Cardiomyopathy: A US Claims Analysis. *Value in Health*. 2021;24:S73.
64. Pickard AS, Law EH, Jiang R, et al. United States Valuation of EQ-5D-5L Health States Using an International Protocol. *Value in health : the journal of the International Society for Pharmacoeconomics and Outcomes Research*. 2019;22(8):931-941.
65. Institute for Clinical and Economic Review. 2020-2023 Value Assessment Framework. [https://icer-review.org/wp-content/uploads/2019/05/ICER\\_2020\\_2023\\_VAF\\_013120-4.pdf](https://icer-review.org/wp-content/uploads/2019/05/ICER_2020_2023_VAF_013120-4.pdf). Published 2020. Accessed.
66. Pearson SD. The ICER Value Framework: Integrating Cost Effectiveness and Affordability in the Assessment of Health Care Value. *Value in health : the journal of the International Society for Pharmacoeconomics and Outcomes Research*. 2018;21(3):258-265.



# Report Supplement

# A. Background: Supplemental Information

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## A1. Definitions

The outcomes in the key trials include the following variables:

- **Kansas City Cardiomyopathy Questionnaire (KCCQ)**<sup>31</sup>: This is a disease-specific patient-reported outcome specific for patients with heart failure. The instrument is based on a self-administered 23-item questionnaire that quantified patient-reported physical limitations, symptoms, self-efficacy, social interference, and quality of life. The original validation of the KCCQ demonstrated correlation between KCCQ scores and measures of physical limitation, clinician-measured estimate of functional status, another patient-reported measure of general health (the SF-36 scale), and clinical events such as death or hospitalization. The KCCQ ranges from 0-100, with higher scores indicating better health. The KCCQ overall summary score (KCCQ-OS) includes all health domains measured by KCCQ and the KCCQ clinical summary (KCCQ-CS) measures only physical limitations and total symptoms. The KCCQ-OS includes questions such as *“How well do you understand what things you are able to do to keep your heart failure symptoms from getting worse?”* that would be reflected in the KCCQ-OS but not the KCCQ-CS.
- **New York Heart Association (NYHA) Functional Classification**<sup>42</sup>: The NYHA classification is a clinician-assessed measure of functional status broadly applicable to patients with cardiac disease, including angina from coronary artery disease but also exertional intolerance from heart failure. Class I refers to patients with cardiac disease but without limitations of physical activity. Class II refers to patients with cardiac disease resulting in slight limitation of physical activity. Class III refers to patients with cardiac disease resulting in marked limitation of physical activity. Class IV refers to patients with cardiac disease resulting in inability to exert physically at all and/or the presence of symptoms at rest.
- **Peak VO<sub>2</sub>**<sup>43</sup>: The maximal oxygen consumption of a patient estimated from peak work rate. This provides an objective, quantitative estimate of the functional capacity of a patient. Functional capacity can be limited by cardiac function but also other physiological processes including pulmonary function, the ability of the circulatory system to deliver oxygenated blood to muscle tissues, and other processes.
- **Left ventricular outflow tract (LVOT) gradient**: The LVOT gradient is the pressure gradient in the LVOT, the conduit through which blood passes from the left ventricle of the heart to the aorta. Patients with obstructive HOCM have gradients that cause pressure drops in the LVOT, impairing the ability of the heart to provide blood to the rest of the body.

## A2. Potential Cost-Saving Measures in Symptomatic HOCM

ICER includes in its reports information on wasteful or lower-value services in the same clinical area that could be reduced or eliminated to create headroom in health care budgets for higher-value innovative services (for more information, see <https://icer.org/our-approach/methods-process/value-assessment-framework/>). These services are ones that would not be directly affected by mavacamten (e.g., need for septal myectomy or ablation), as these services will be captured in the economic model. Rather, we are seeking services used in the current management of symptomatic HOCM beyond the potential offsets that arise from a new intervention. During stakeholder engagement and public comment periods, ICER encouraged all stakeholders to suggest services (including treatments and mechanisms of care) currently used for patients with symptomatic HOCM that could be reduced, eliminated, or made more efficient. No suggestions were received.

## B. Patient Perspectives: Supplemental Information

### **B1. Methods**

ICER collaborated with the Hypertrophic Cardiomyopathy Association to conduct an online patient-input questionnaire to gather more insight on people living with and people who care for those living with HCM. Responders were recruited from social media and through a listserv of Hypertrophic Cardiomyopathy Association members. The survey results informed the scope of our review and helped focus our assessment on outcomes of most interest to patients and caregivers.

Because this survey consisted of qualitative, open-ended questions, responses were categorized and frequency of each category were quantified, summed, and then put into graphical or table form. Respondents could have more than one category assigned to their response and the categories are not all mutually exclusive; thus, the number of responses varies by question. Select individual unedited quotes are reported below to more fully capture narrative experiences of those living with HCM that were not fully captured by our quantitative summary. All responses were anonymous.

### **B2. Results**

ICER received a total of 641 responses on the survey, including 606 patients, six patient advocates, and 29 caregivers/family members. We limited our summary below to 541 responses from patients that included information relevant to our review.

#### **Experience with HCM**

##### ***Type of HCM***

While 14.3% and 12.5% of patients responded that the type of HCM that they live with is either obstructive and/or associated with a known, specific HCM gene variant, a large majority of patients (67.1%) did not know the subtype of HCM that they live with. Additionally, 2.4% of patients reported having HCM without obstruction. Since these categories were not mutually exclusive, patients could have reported they live with a known HCM gene variant and a specific HCM subtype (Table B1).

**Table B1. HCM Type**

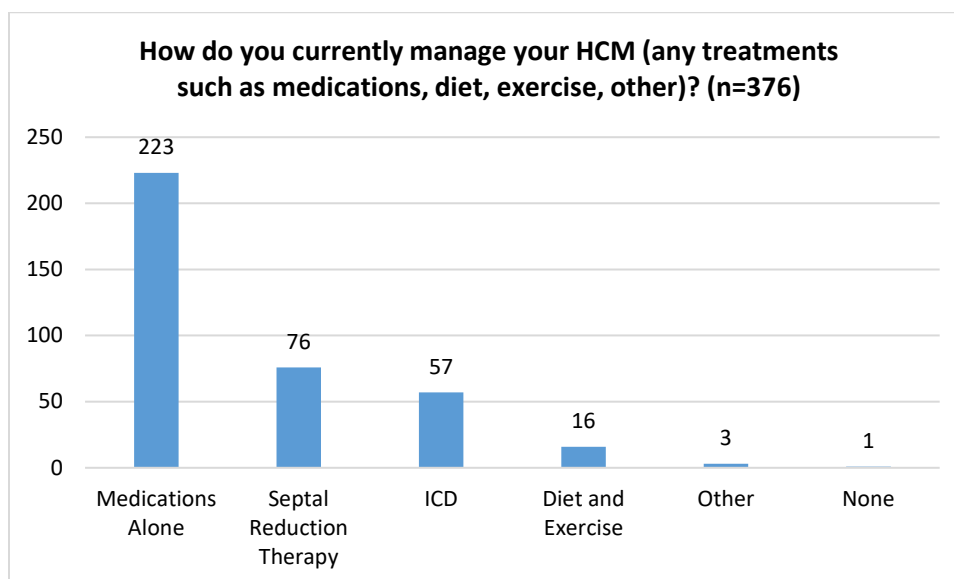
HCM Type (N=538)	n (%)
I Don't Know	361 (67.1%)
Obstructive	77 (14.3%)
Genotype	67 (12.5%)
Other	20 (3.7%)
Non-Obstructive	13 (2.4%)

n: number, N: total number

### ***HCM Treatment and Management***

A figure depicting patients' current management of HCM is below (Figure B1). Use of medications alone was reported by most patients (59%), followed by septal reduction therapy (20%), ICD (15%), and diet and exercise alone (4.3%).

**Figure B1. Management of HCM**



HCM: hypertrophic cardiomyopathy, ICD: implantable cardiac device, n: number

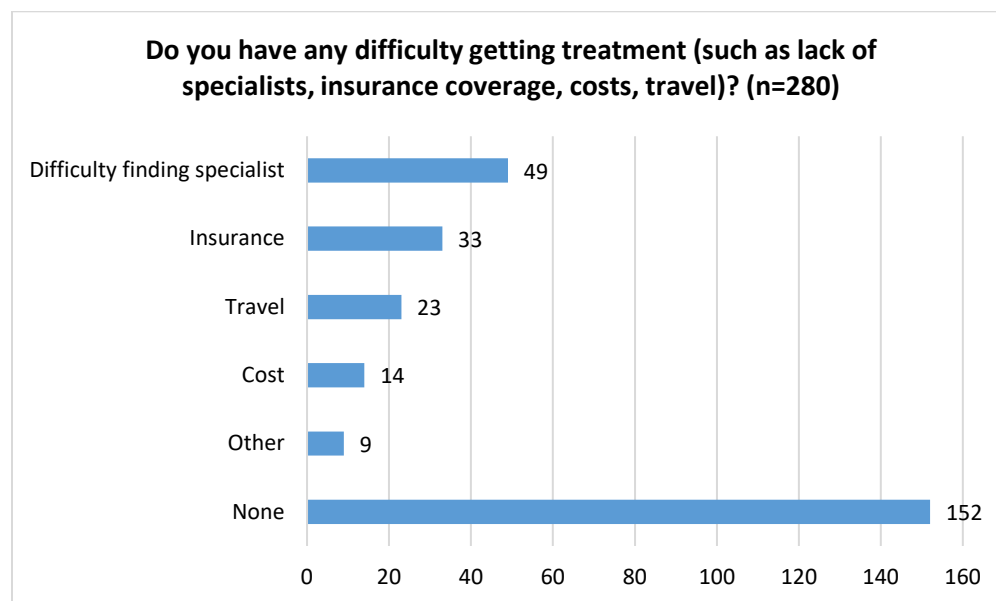
- “I try with diet and physical activity. I couldn't stand beta blockers. My doctor advises me to have a myectomy, but I really don't want open heart surgery. I have a lot of shortness of breath on activity, even walking, and forget walking up hill.”
- “Twice daily Toprol XL (my body metabolizes it quickly for some reason and we found out the hard way that I get tachycardic if I take it only once daily) and an ICD for safety. I've experienced ventricular tachycardia and atrial fibrillation each a couple times (or just one several times, it was hard to tell) but never ventricular fibrillation, thankfully. My heart has behaved itself for almost 18 years. I have a lot of fatigue but no more cardiac events. I do what I can to keep stress to a minimum.”

- “I have two sons that have each had a myectomy in their early and late 30s, and one also has a mechanical mitral valve at 23. Each of us have defibrillator/pacemaker.”
- “Medications — fairly large doses of Norpace CR and metoprolol, as well as moderate exercises and lifestyle changes like not exercising after meals, eating small meals, avoiding being outside on hot days, and hydrating.”

### ***Treatment Access Issues***

Barriers to acquiring treatment are demonstrated in Figure B2 below. Most patients (54%) reported no difficulties in getting treatment. The most cited barriers to treatment included: difficulty finding a specialist (18%), issues with insurance (12%), and travel (8%).

**Figure B2. Difficulty Getting Treatment**



n: number

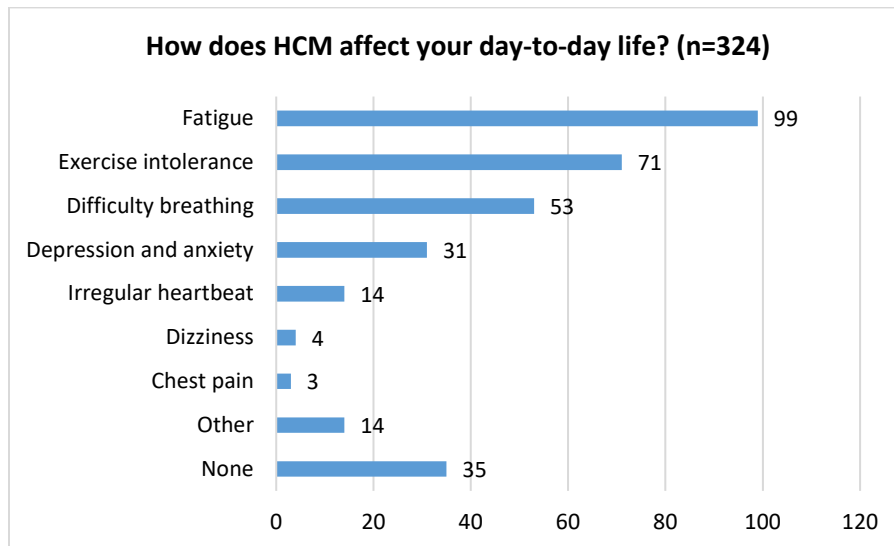
- “We live in Illinois and have to travel to Cleveland for treatment. During my surgery, we stayed 21 days in a hotel. The lack of specialists and high-volume hospitals for this is very limited. Even in Chicago, the ‘specialist’ there told me I would need to get evaluated for transplant. Global knowledge is very challenging for care. Travel requirements for receiving quality care are burdensome... We had to open a credit card just for travel expenses for Cleveland. HMO insurance is free and 100% coverage with my husband’s employer, they would not allow coverage of Cleveland with multiple appeals. For us to switch to PPO, my husband pays \$330 per paycheck, percent of all services, and a \$10,000 out-of-pocket deductible. We are actually in process of selling our home and downsizing due to drowning in medical debt from surgeries, checkups, and travel expenses.”

- “The nearest center of excellence is more than six hours away. Travel is difficult during the months of October-May due to weather. The time off work that a trip requires is a situation as well. The money it costs for said travel is also a financial burden as I still have to pay for insurance, patient portion insurance doesn't cover as well as fuel, food, and a place to stay. It adds up quickly.”
- “I have two daughter who have HCM as well as myself. The cost of yearly screening and testing is a huge financial burden on our family as well as I’m sure other HCM families even after insurance.”
- “Yes, many cardiologists have not studied the disease as it is a sub-specialty. It is weird when the patient knows more than they. It worries me as I feel I always need to be alert to head off disaster. What if I appear unconscious in an ER or hospital? I don't generally feel safe away from Mayo Clinic.”
- “Yes. My insurance does not cover a center of excellence in HCM. As a result, I must stay informed about the latest evidence-based guidelines and advocate for myself. It’s exhausting and time consuming.”
- “There are no cardiologists in my borough who understand HCM, so I was misdiagnosed for 54 years. Also, after my septal myectomy, there was no local cardiac rehab available to me and I could not go into a nursing facility because I wasn't old enough.”
- “There is a severe shortage of Norpace CR, and I can only order it month-to-month from a pharmacy in New York at a co-pay of \$280 per month plus mailing expense. Large pharmaceutical chains like CVS and Walgreens no longer carry it. I am on Medicare, and only one drug plan covers it at all. I have tried a generic that must be taken four times a day, and cut back on my dosage to save money. Neither worked for me. I live with the fear that I will no longer be able to obtain a medication I have been using successfully for more than 15 years.”

## HCM Symptoms

Fatigue was the most reported symptom of HCM (30.6%), followed by exercise intolerance (21.9%), difficulty breathing (16.4%), and depression and anxiety (9.6%) (Figure B3).

**Figure B3. How HCM Affects Day-to-Day Life**



HCM: hypertrophic cardiomyopathy, n: number

- “Arrhythmias, exhaustion, retaining fluid in legs makes exercise/stairs/walking distances challenging, short of breath impacts everything, difficulty sustaining active sex life, difficulty being the active parent I wish to be for my kids.”
- “My heart is continuing to get worse and I’m transitioning into congestive heart failure. For the first 10 to 15 years after my myectomy, I didn’t feel that limited. The main issues were the defibrillator maintenance and battery replacements. But now I do have trouble breathing with a lot of exertion, so I am somewhat limited in recreational activities that I enjoyed like hiking. Also, I’m not supposed to shovel snow, so I have to hire somebody to do that. And I’m more restrictive in carrying heavy things than I used to be. As I have more restrictions, it’s frustrating and humbling.”
- “It has a huge impact on my life, and it affects my job. I can’t walk more than 10 minutes without stopping to catch my breath, I can’t work out like I used to, I am gaining weight, I can only walk up one flight of stairs at a time, I am embarrassed to be around people who may see me struggling to breathe – it keeps me secluded in my home. And what is most depressing is seeing how I am getting worse and can’t stop it.”



- “Breathlessness getting out of bed, washing my hair, etc. I work but have had to reduce to a sedentary job and decrease my hours. Can’t do garden chores. Have to space out home duties (can’t change all the sheets in the house in the same day).”
- “Have to be careful when working out for heart rate to stay within the given beats per minute. Some symptoms are debilitating, and I have to always be on my toes. It continuously plays on my mind so keeping stress levels down is not easy.”
- “I become short of breath on exertion, especially going up stairs or uphill. I love to be active, but I lag behind my family and friends on walks and hikes. I use an electric bicycle, or I would not be able to bike ride with others.”

## Treatment Effects

### *Treatment Effectiveness*

When asked about how well their treatments work, about half of patients reported that their treatments work well (50%), a third thought their treatments work okay (33%), and 9% thought their treatments don’t work.

**Table B2. Treatment Effectiveness**

Treatment Effectiveness (N=341)	n (%)
<b>They Work Well</b>	172 (50.4%)
<b>They Work Okay</b>	114 (33.4%)
<b>They Don't Work</b>	31 (9.1%)
<b>Other</b>	24 (7.0%)

n: number, N: total number

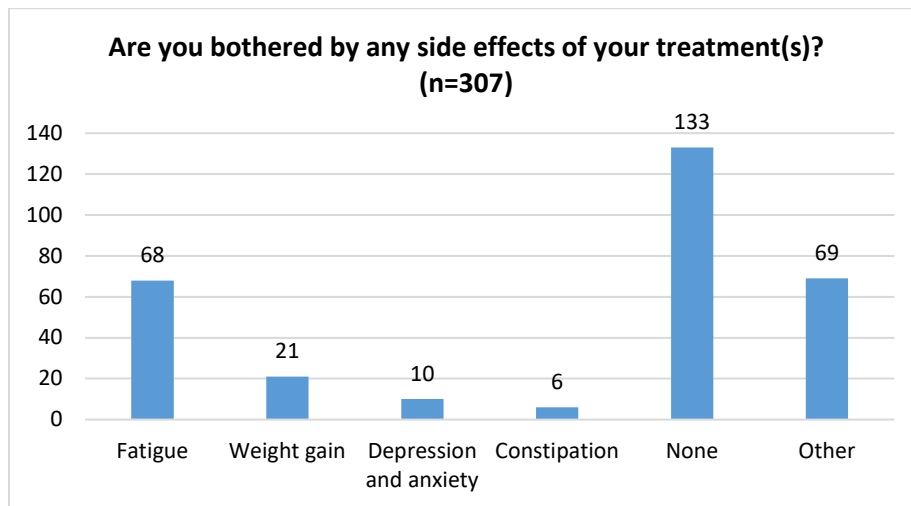
- “Fairly well, but it is still worrisome knowing that something is wrong and feeling the symptoms of the HCM despite medically and lifestyle treatments.”
- “I felt great after the myectomy in 2002. Prior to that I was on so much medication that I was always struggling from the side effects, even though I did work full-time and had a pretty active life. Once I had the myectomy, I did well for about 15 years, at which point my ejection fraction started to dip. For the most part, I still feel like I live a pretty normal life without too many restrictions, but as more medications are added due to my heart weakening, I’m starting to deal with side effects again.”
- “I’m sure they are helping maintain my lower blood pressure but not so sure they are really helping my shortness of breath.”

- “The drug treatments have been effective in slowing the increase in gradient. And reducing the LVOT disruption. However, the side effects of the treatments are about the side as the physical effects of the disease.”
- “They keep my blood pressure under control, help prevent heart pain and keep my heart rate from being too fast. They work well, but are not a cure for the condition, they just help me manage with the condition.”
- “I am so much better than at my sickest, but very far from healthy. I don't know when I will have a bad day and no longer do a lot of the charitable work that I used to do out of fear that I will have heart issues and put someone at risk.”
- “They have definitely decreased my angina and my arrhythmias. But they also contribute to my tiredness and possibly to my fluid retention.”

### ***Side Effects of Treatment***

The most reported side effect of treatment was fatigue (22.1%), followed by weight gain (6.8%), and depression and anxiety (3.3%). The majority of patients reported that they had no side effects (Figure B4).

**Figure B4. Treatment Side Effects**



n: number

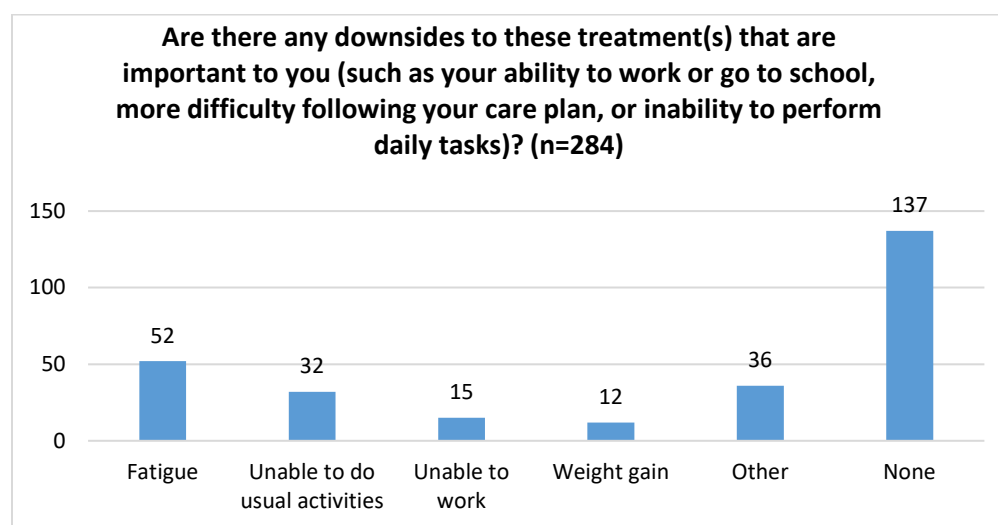
- “When I tried metoprolol, it made me really tired, lethargic, depressed, and gain weight, even on a very small dose. So, I gave up on beta blockers.”
- “I’m 61 years old. I have little interest in the joys of life. I believe my meds are decreasing my interest in sex.”

- “Yes, I think beta blockers and calcium channel blockers being taken to slow down the blood pressure may be having some side effects as I notice some swelling in ankles and feet sometimes.”
- “Yes, prior to my myectomy, I felt like I was walking underwater. I was fatigued all the time, had digestive issues, memory problems. This had a lot to do with the high dosages I was on, 480 mg of Inderal, 800 mg of Norpace. After the myectomy, I wasn’t on that much medication, and didn’t really feel side effects. Now, being on IV medications, I am noticing them coming back, some issues with depression and anxiety, and some lowered sexual functioning.”

### ***Downsides to Treatment***

Fatigue was the most reported downside to treatment for HCM (18.3%), followed by inability to perform unusual activities and inability to work (11.3% and 5.3%, respectively) (Figure B5). Most patients, however, reported “no” or “other downsides not listed” (12.7% and 48.2%, respectively).

**Figure B5. Treatment Downsides**



n: number

- “Daily tasks that involve bending over (laundry, cleaning floors) are still difficult. Limits on types of exercise are frustrating, but there are work arounds. Difficulty traveling by air and long car rides limit business opportunities and visits to family.”
- “I have been on a do-not-work order for almost four years now due to my intolerance to medication and to help my heart not over working itself as my blood pressure drops when my heart rate rises, and I become very breathless and at times my hands and feet turn purple from lack of blood flow and swelling sucks.”

- “The downside is really that I feel so dependent on these medications for survival and to get through my daily activities. The side effects don't disrupt my routine, but managing the medications and the HCM is very stressful and takes its toll on me and my family.”
- “Being 100% dependent on a device is challenging. I always have to think about keeping magnets or other electronics away from the ICD.”
- “I think the medications cause fatigue and brain fog that prompted me to take an early retirement from work as I felt I was not capable of performing my work tasks to full capability/commitment.”
- “Yes, can't always perform daily tasks. Worry about driving. Always check to see if there is a shoulder I can pull off into. What if there is no shoulder? What if I have atrial fibrillation? I have become a lethal weapon. I try to make all appointments in the morning. I have cataract surgery coming up, but I worry. What if I go into atrial fibrillation? At home, I would drop to the floor. I may be flipping a hamburger one minute and on the floor the next.”
- “I was a single mom on beta blockers and had a hard time doing anything – my kids needed me to drive, make meals, etc. and sometimes I was just too tired.”

### ***Impact of Treatment On Caregivers***

About a third (33%) of patients reported that treatments had no impact on caregivers, while 22% reported that treatments had a large impact and 10% reported that treatments had a small impact (Table B3).

**Table B3. Treatment Caregiver Impact**

<b>Treatment Caregiver Impact (N=257)</b>	<b>n (%)</b>
<b>Large Impact</b>	56 (21.8%)
<b>Small Impact</b>	25 (9.7%)
<b>No Impact</b>	84 (32.7%)
<b>Not Applicable</b>	76 (29.6%)
<b>Other</b>	16 (6.2%)

n: number, N: total number

- “As a patient, because medications lower your heart rate and thereby everything, on specific days you might become more quiet and not as functioning and this could add physical and mental burden to your caregiver. As a patient and depending on the dosage of your medications, you are not as active or capable to satisfy your partner physically or sexually or engage in activities that might bring joy to both of you and as a family.”

- “My condition itself has been enormously stressful to my family. My septal myectomy has improved their lives as I can function better now. I don’t tell them how bad I am feeling.”
- “Financial impact on the family has been intense – we max out co-pays and deductibles EVERY year. We don’t take vacations and we must go without things others take for granted. My husband and family members worry about my health causing stress and lots of trips to doctors, hospitals and ‘rescue’ calls when I am not feeling well, which disrupts normal life.”
- “No impact at this time to caregivers since the device was implanted in Minneapolis in 2012. I am independent and ambulatory. No caregiver needed.”

## C. Clinical Guidelines

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Guidelines relevant to treatment of patients, including those with symptomatic HOCM have been published by a joint committee in the US as well as other non-US based organizations. Key elements focusing on the management of symptoms in HCM including HOCM from these guidelines are summarized below. The guidelines address many other topics relevant to HCM, including HOCM, including risk stratification for sudden cardiac death, genetic testing, and diagnostic imaging.

### **American College of Cardiology and American Heart Association<sup>9</sup>**

In 2020, the joint committee on clinical practice guidelines of the American College of Cardiology and the American Heart Association issued a report on diagnosis and treatment for all patients with HCM, including those with symptomatic HOCM. These guidelines emphasize the importance of shared decision making for testing and treatment options. They explicitly recommend (level 2a) consultation with or referral to comprehensive HCM centers for complex management decisions. When indicated, the guidelines recommend (class 1) that septal reduction procedures including surgical myectomy and septal ablation are performed at these specialized centers.

With respect to pharmacological therapies for patients with HOCM and exertional limitations, such as shortness of breath, the guidelines recommend beta blockers as first-line therapy (class 1). For patients for whom beta blockers are ineffective or poorly tolerated, centrally-acting calcium channel blockers are recommended (class 1). For patients with persistent severe symptoms attributable to left ventricular outflow obstruction, either adding disopyramide or performing a septal reduction procedure is recommended (class 1). For patients with clinical fluid retention, cautious use of diuretics, avoiding dehydration can be considered (class 2b). Vasodilating blood pressure agents including angiotensin-converting enzyme inhibitors, dihydropyridine calcium channel blockers (such as amlodipine), and digoxin are reasonable to consider stopping, given that they can worsen left ventricular outflow tract obstruction (class 2b). Finally, in patients with severe shortness of breath at rest, very high left ventricular outflow tract gradients (>80-100 mm Hg), or low blood pressure, calcium channel blockers are contraindicated because of potential harm (class 3).

For patients who remain severely symptomatic because of LVOT gradients despite medical therapy, guidelines support septal reduction therapy (class 1). Patients who are at acceptable surgical risk and/or who have other surgical heart disease (such as intrinsic structural mitral valvular dysfunction) should receive surgical myectomy (class 1). Conversely, patients who are at elevated surgical risk should receive alcohol septal ablation (class 1). It is also reasonable to consider surgical myectomy for patients with severe progressive pulmonary hypertension or mitral regurgitation, left atrial enlargement with atrial fibrillation, poor functional capacity due to LVOT obstruction, or

young adults with very high resting LVOT gradients (>100 mm Hg) (class 2b). Any type of septal reduction, including alcohol septal ablation and surgical myectomy, is contraindicated for patients with HCM who are asymptomatic and have normal exercise capacity (class 3).

## **European Society of Cardiology**

The European Society of Cardiology convened a task force for diagnosis and management of hypertrophic cardiomyopathy and most recently issued guidelines in 2014.<sup>44</sup>

For patients with symptomatic HOCM, guidelines recommend beta blockers first and then calcium channel blockers for those patients who are intolerant to beta blockers (class 1). Unlike American guidelines, which offer disopyramide or septal reduction therapies next as a choice, the European Society of Cardiology guidelines explicitly recommend disopyramide for patients with persistent symptoms (class 1). Verapamil is explicitly favored in European guidelines over diltiazem (class 2a). Unlike American guidelines, which recommend that disopyramide is used only with beta blockers or calcium channel blockers (due to the risk of enhanced atrioventricular nodal conduction if atrial fibrillation develops), the European guidelines allow the consideration of disopyramide as monotherapy (class 2b). For patients with clinical congestion judicious use of diuretics can be considered (class 2b).

For patients with resting or provoked gradients of 50 mm Hg or greater and who have NYHA class III-IV symptoms despite maximum tolerated medical therapy, European guidelines recommend septal reduction therapies by highly experienced operators within expert multidisciplinary teams (class 1). While surgical myectomy is favored (class 1) when there is concurrent cardiac surgical disease, European guidelines emphasize uncertainty about the comparative effectiveness of septal ablation versus myectomy.

For patients with HOCM, the guidelines recommend generally against the use of arterial and venous dilators (class 2a) and more strongly against digoxin (class 3) since these agents can worsen LVOT obstruction. The guidelines also emphasize that restoration of sinus rhythm or better rate control is recommended before considering invasive septal reduction therapies (class 2a).

## **National Institute for Health and Care Excellence**

In 2004, the United Kingdom's National Institute for Health and Care Excellence cites "adequate" evidence to support the use of septal ablation for patients with symptomatic HOCM as an alternative to surgical myectomy.<sup>45</sup>

## **Ludwig Boltzmann Institute for Health Technology Assessment**

In 2013, the Ludwig Boltzmann Institute for Health Technology Assessment in Austria issued a report recommending that septal ablation only be performed in highly-specialized centers and all patients with the procedure be enrolled in procedural registries.<sup>46</sup>



## D. Comparative Clinical Effectiveness:

### Supplemental Information

#### **D1. Detailed Methods**

##### **PICOTS (Population, Intervention, Comparator, Outcomes, Timing, Setting)**

###### ***Population***

The population of focus for the review is adults with symptomatic HOCM. As data allowed, we planned to review any available data in children with symptomatic HOCM. We also separately reviewed available evidence for the intervention in patients with symptomatic HCM without obstruction.

###### ***Interventions***

The intervention of interest is mavacamten in addition to usual care.

###### ***Comparators***

Mavacamten was compared with usual care. This included comparisons with adding mavacamten to existing therapy as estimated by the placebo arms of clinical trials, but also comparisons with alternative therapies including medications typically used later than first line (e.g., disopyramide) and septal reduction procedures (surgical myectomy and septal ablation).

###### ***Outcomes***

The outcomes of interest are described in the list below.

- Patient-Important Outcomes
  - Symptoms of HOCM such as exertional intolerance, fatigue, shortness of breath, dizziness, arrhythmia, chest discomfort, mental acuity (with particular attentiveness to patient-reported outcomes)
  - Requirement for exercise restriction
  - Anxiety and depression
  - Overall mortality
  - Sudden cardiac death
  - Need for implantation of ICD
  - Heart failure
  - Rate of septal reduction therapy (septal ablation or myectomy)

- Atrial fibrillation and stroke
  - Adverse events including:
    - Treatment-emergent adverse events and serious adverse events
- Other Outcomes
  - Peak oxygen consumption (pVO<sub>2</sub> exercise capacity)
  - Post-exercise LVOT gradient and resting LVOT gradient
  - Left ventricular ejection fraction
  - NYHA functional class
  - Cardiac biomarkers such as NT-proBNP and hs-cTnI

### ***Timing***

Evidence on intervention effectiveness and harms were derived from studies of any duration.

### ***Settings***

All relevant settings were considered, with a focus on outpatient settings in the US.

**Table D1. PRISMA 2009 Checklist**

Checklist Items		
TITLE		
Title	1	Identify the report as a systematic review, meta-analysis, or both.
ABSTRACT		
Structured Summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.
INTRODUCTION		
Rationale	3	Describe the rationale for the review in the context of what is already known.
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).
METHODS		
Protocol and Registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.
Eligibility Criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.
Information Sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.
Study Selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).
Data Collection Process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.
Data Items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.
Risk of Bias in Individual Studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.
Summary Measures	13	State the principal summary measures (e.g., risk ratio, difference in means).
Synthesis of Results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I <sup>2</sup> ) for each meta-analysis.
Risk of Bias Across Studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).
Additional Analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.
RESULTS		
Study Selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.
Study Characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.
Risk of Bias Within Studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).

Checklist Items		
<b>Results of Individual Studies</b>	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.
<b>Synthesis of Results</b>	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.
<b>Risk of Bias Across Studies</b>	22	Present results of any assessment of risk of bias across studies (see Item 15).
<b>Additional Analysis</b>	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).
DISCUSSION		
<b>Summary of Evidence</b>	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., health care providers, users, and policy makers).
<b>Limitations</b>	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).
<b>Conclusions</b>	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.
FUNDING		
<b>Funding</b>	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.

From: Moher D, Liberati A, Tetzlaff J, Altman DG. The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(6): e1000097. doi:10.1371/journal.pmed1000097.

## Data Sources and Searches

Procedures for the systematic literature review assessing the evidence on new therapies for symptomatic HOCM followed established best research methods. We conducted the review in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines.<sup>47</sup> The PRISMA guidelines include a checklist of 27 items, which are described further in Table D1.

We searched MEDLINE, EMBASE, Cochrane Database of Systematic Reviews, and Cochrane Central Register of Controlled Trials for relevant studies. Each search was limited to English-language studies of human subjects and excluded articles indexed as guidelines, letters, editorials, narrative reviews, case reports, or news items. We included abstracts from conference proceedings identified from the systematic literature search. All search strategies were generated utilizing the Population, Intervention, Comparator, and Study Design elements described above. The proposed search strategies included a combination of indexing terms (MeSH terms in MEDLINE and Emtree terms in EMBASE) as well as free-text terms.

To supplement the database searches, we performed manual checks of the reference lists of included trials and systematic reviews and invited key stakeholders to share references germane to the scope of this project. We also supplemented our review of published studies with data from conference proceedings, regulatory documents, information submitted by manufacturers, and

other grey literature when the evidence met ICER standards (for more information, see <https://icer.org/policy-on-inclusion-of-grey-literature-in-evidence-reviews/>). Where feasible and deemed necessary, we also accepted data submitted by manufacturers “in-confidence,” in accordance with ICER’s published guidelines on acceptance and use of such data (<https://icer.org/guidelines-on-icers-acceptance-and-use-of-in-confidence-data-from-manufacturers-of-pharmaceuticals-devices-and-other-health-interventions/>).

**Table D2. Search Strategy of Medline 1996 to Present with Daily Update and Cochrane Central Register of Controlled Trials**

1	Exp Cardiomyopathy, Hypertrophic/
2	((((hypertroph* or obstruct*) adj3 (cardiomyopath* or subaortic stenosis or Asymmetric*)) or hcm or hocm or ihss or Symptomatic obstructive hypertrophic cardiomyopathy).ti,ab.
3	1 OR 2
4	(Mavacamten).ti,ab
5	('myk 461' OR myk461).ti,ab
6	('sar 439152' OR sar439152).ti,ab
7	4 OR 5 OR 6
8	3 AND 7
9	(addresses or autobiography or bibliography or biography or comment or congresses or consensus development conference or duplicate publication or editorial or guideline or in vitro or interview or lecture or legal cases or legislation or letter or news or newspaper article or patient education handout or periodical index or personal narratives or portraits or practice guideline or review or video audio media).pt
10	8 NOT 9
11	animals.mp. not (humans and animals).sh.
12	10 NOT 11
13	limit 12 to English language

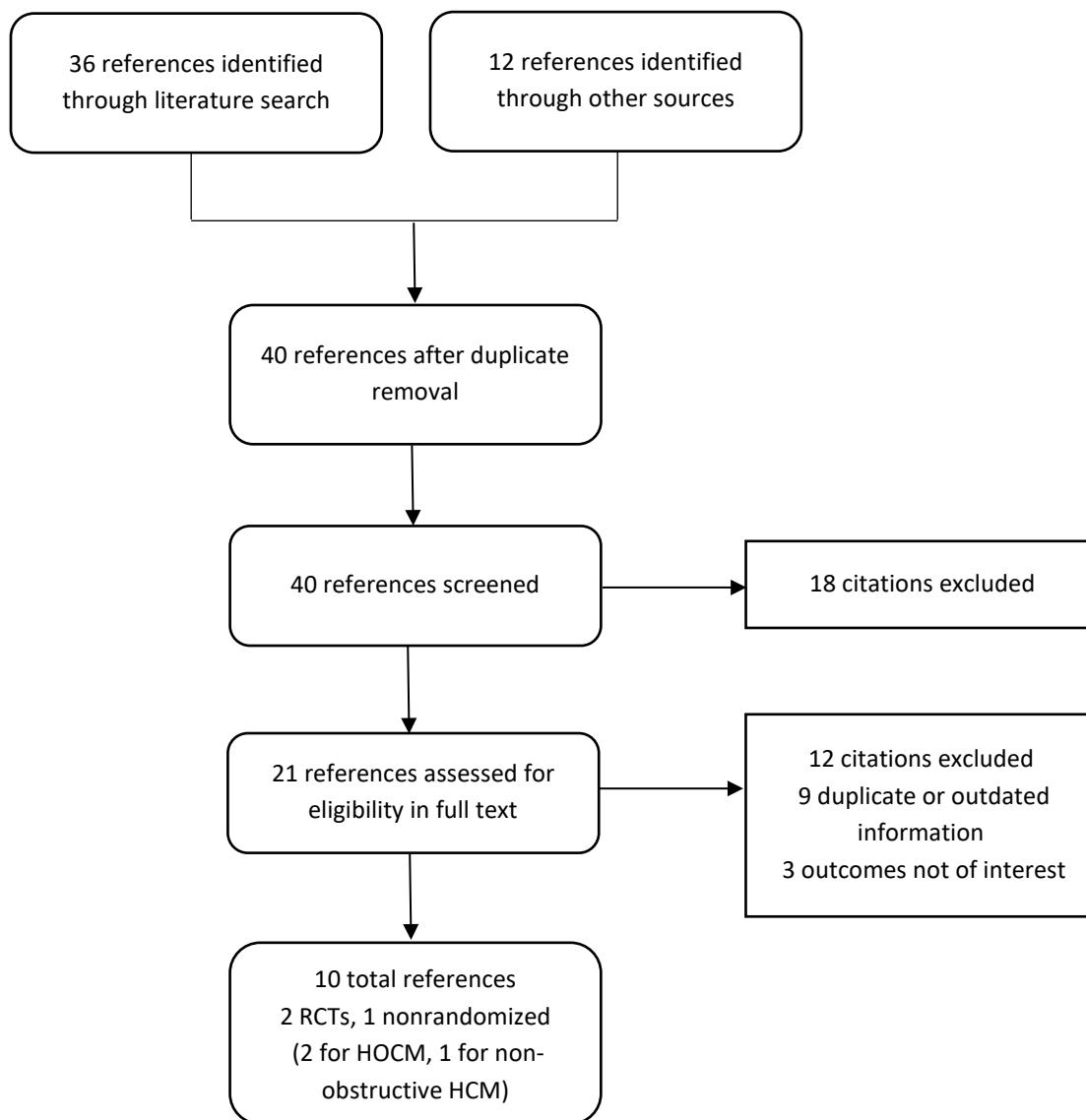
\*Search last updated on August 30, 2021.

**Table D3. Search Strategy of EMBASE SEARCH**

#1	'hypertrophic obstructive cardiomyopathy'/exp OR 'hypertrophic obstructive cardiomyopathy'
#2	cardiomyopathy OR 'hypertrophic obstructive' OR 'cardiomyopathy, obstructive' OR 'hypertrophic cardiomyopathy, obstructive' OR 'myocardiopathy, obstructive' OR 'obstructive cardiomyopathy' OR 'obstructive hypertrophic myocardiopathy' OR 'obstructive myocardiopathy' OR 'hypertrophic cardiomyopathy' OR (((hypertroph* OR obstruct*) NEAR/3 (cardiomyopath* OR 'subaortic stenosis' OR Asymmetric*)) OR hcm OR hocm OR ihss):ti,ab
#3	#1 OR #2
#4	Mavacamten/exp OR mavacamten
#5	('myk 461' OR myk461 OR 'sar 439152' OR sar439152):ti,ab
#6	#4 OR #5
#7	#3 AND #6
#8	('case report'/de OR 'human tissue'/de OR 'nonhuman'/de OR 'practice guideline'/de OR 'questionnaire'/de OR 'chapter'/it OR 'conference review'/it OR 'editorial'/it OR 'letter'/it OR 'note'/it OR 'review'/it OR 'short survey'/it)
#9	#7 NOT #8
#10	('animal'/exp OR 'nonhuman'/exp OR 'animal experiment'/exp) NOT 'human'/exp
#11	#9 NOT #10
#12	#11 AND [english]/lim

\*Search last updated on August 30, 2021.

**Figure D1. PRISMA Flowchart Showing Results of Literature Search for Mavacamten**



## Study Selection

We performed screening at both the abstract and full-text level. A single investigator screened all abstracts identified through electronic searches according to the inclusion and exclusion criteria described earlier. We did not exclude any study at abstract-level screening due to insufficient information. For example, an abstract that did not report an outcome of interest would be accepted for further review in full text. We retrieved the citations that were accepted during abstract-level screening for full text appraisal. One investigator reviewed full papers and provided justification for exclusion of each excluded study.

## Data Extraction and Quality Assessment

We used criteria published by the US Preventive Services Task Force (USPSTF) to assess the quality of randomized controlled trials and comparative cohort studies, using the categories “good,” “fair,” or “poor” (see Table F2).<sup>48</sup> Guidance for quality ratings using these criteria is presented below, as is a description of any modifications we made to these ratings specific to the purposes of this review.

**Good:** *Meets all criteria: Comparable groups are assembled initially and maintained throughout the study; reliable and valid measurement instruments are used and applied equally to the groups; interventions are spelled out clearly; all important outcomes are considered; and appropriate attention is paid to confounders in analysis. In addition, intention-to-treat analysis is used for randomized controlled trials.*

**Fair:** *Studies were graded "fair" if any or all of the following problems occur, without the fatal flaws noted in the "poor" category below: Generally comparable groups are assembled initially but some question remains whether some (although not major) differences occurred with follow-up; measurement instruments are acceptable (although not the best) and generally applied equally; some but not all important outcomes are considered; and some but not all potential confounders are addressed. Intention-to-treat analysis is done for randomized controlled trials.*

**Poor:** *Studies were graded "poor" if any of the following fatal flaws exists: Groups assembled initially are not close to being comparable or maintained throughout the study; unreliable or invalid measurement instruments are used or not applied equally among groups (including not masking outcome assessment); and key confounders are given little or no attention. For randomized controlled trials, intention-to-treat analysis is lacking.*

Note that case series are not considered under this rating system – because of the lack of comparator, these are generally considered to be of poor quality.



## Assessment of Level of Certainty in Evidence

We used the [ICER Evidence Rating Matrix](#) to evaluate the level of certainty in the available evidence of a net health benefit among each of the interventions of focus.<sup>49,50</sup>

## Assessment of Bias

As part of our quality assessment, we evaluated the evidence base for the presence of potential publication bias. We performed an assessment of publication bias for mavacamten using the [clinicaltrials.gov](#) database of trials. We selected studies which would have met our inclusion criteria and for which no findings have been published and did not find any evidence of publication bias.

## Data Synthesis and Statistical Analyses

Data on relevant outcomes were summarized in evidence tables and synthesized qualitatively in the body of the review. Due to insufficient evidence and lack of comparative data on disopyramide and septal reduction therapy, we did not perform any network meta-analyses comparing mavacamten with these comparators. Additionally, we did not perform any pairwise meta-analyses due to differences in study design, population characteristics, and outcomes between the mavacamten trials. We instead descriptively made these comparisons in the main report of the review and supplement.

## D2. Additional Clinical Evidence

### Evidence Base

#### *Mavacamten*

The main report focused primarily on outcomes of mavacamten in patients with symptomatic, obstructive HCM. In this section, we also describe outcomes in patients with symptomatic non-obstructive HCM.

#### *Symptomatic Obstructive HCM*

In addition to the pivotal Phase III EXPLORER trial and related long-term extension study (MAVA-LTE, which is described in the sections above), we also identified a Phase II trial of mavacamten for patients with HOCM, PIONEER-HCM<sup>51</sup> and a Phase II trial of mavacamten for patients with non-obstructive HCM (MAVERICK-HCM).<sup>15</sup>

Selected baseline characteristics of EXPLORER are below in Table D4.

**Table D4. Selected Baseline Characteristics of EXPLORER-HCM<sup>24</sup>**

	<b>Mavacamten (n=123)</b>	<b>Placebo (n=128)</b>
<b>Age, Mean (SD)</b>	58.5 (12.2)	58.5 (11.8)
<b>Female Gender, n (%)*</b>	57 (46)	45 (35)
<b>Race, n (%):</b>		
<b>White</b>	115 (93)	114 (89)
<b>Black or African American</b>	1 (1)	5 (4)
<b>Native American or Alaskan Native</b>	0	1 (1)
<b>Asian</b>	4 (3)	2 (2)
<b>Unknown</b>	3 (2)	6 (5)
<b>Medical History, n (%):</b>		
<b>HOCM Gene Variant, n/N</b>	28/90 (31)	22/100 (22)
<b>Family History of HOCM</b>	33 (27)	36 (28)
<b>Atrial Fibrillation*</b>	12 (10)	23 (18)
<b>Septal Reduction Therapy</b>	11 (9)	8 (6)
<b>ICD</b>	27 (22)	29 (23)
<b>Background HOCM Therapy, n (%):</b>		
<b>Beta Blocker</b>	94 (76)	95 (74)
<b>Calcium Channel Blocker</b>	25 (20)	17 (13)
<b>Neither</b>	4 (3)	16 (13)
<b>NYHA Class II, n (%)</b>	88 (72)	95 (74)
<b>NYHA Class III, n (%)</b>	35 (28)	33 (26)
<b>pVO<sub>2</sub>, Mean mL/kg Per Min (SD)</b>	18.9 (4.9)	19.9 (4.9)
<b>NT-proBNP, Geometric Mean, ng/L (CV%)*</b>	777 (136)	616 (108)
<b>Hs-CTnI, Geometric Mean, ng/L (CV %)</b>	12.5 (208)	12.5 (373)
<b>Echocardiographic Parameters:</b>		
<b>LVEF Mean, % (SD)</b>	74 (6)	74 (6)
<b>Maximum LV Wall Thickness, Mean mm (SD)</b>	20 (4)	20 (3)
<b>LVOT Gradient, Rest, Mean mm Hg (SD)</b>	52 (29)	51 (32)
<b>LVOT Gradient, Valsalva, mm Hg (SD)</b>	72 (32)	74 (32)
<b>LVOT Gradient, Post-Exercise, mm Hg (SD)</b>	86 (34)	84 (36)

CV: coefficient of variation, HOCM: hypertrophic obstructive cardiomyopathy, Hs-CTnI: high-sensitivity cardiac troponin I, ICD: implantable cardiac device, kg: kilogram, L: liter, LF: left ventricular, LVEF: left ventricular ejection fraction, LVOT: left ventricular outflow tract, mm: millimeter, mm Hg: millimeter of mercury, n: number, N: total number, ng: nanogram, NT-proBNP: N-terminal pro B-type natriuretic peptide, NYHA: New York Heart Association, pVO<sub>2</sub>: peak oxygen consumption, SD: standard deviation

\*Indicates a statistically significant difference between groups.

PIONEER was a prospective, open-label multi-center study conducted at five sites in the US with two sequential cohorts totaling 21 patients (Table D12).<sup>51</sup> Patients were eligible to participate if they were 18-70 years old, had HCM, with LV wall thickness  $\geq 15$  mm at time of initial diagnosis or  $\geq 13$  mm with a positive family history of HCM, LVEF  $\geq 55\%$ , resting LVOT gradient  $\geq 30$  mm Hg and post-exercise peak LVOT gradient  $\geq 50$  mm Hg, and NYHA class II or higher.<sup>52</sup>

In cohort A, patients were taken off concomitant beta-blockers, calcium-channel blockers, and disopyramide two weeks prior to treatment with a high dose of mavacamten (10 or 15 mg per day depending on body weight). In cohort B, patients were allowed to continue use of beta blockers

and were started on a lower dose of mavacamten (2 mg per day, increasing to 5 mg per day at four weeks depending on resting LVOT gradient). Patients were followed for 12 weeks on treatment followed by a four-week washout period. The primary outcome was change in post-exercise LVOT gradient at 12 weeks compared to baseline. Secondary outcomes included post-exercise LVOT gradient less than 30 mm Hg, change in numerical rating dyspnea score, change in pVO<sub>2</sub>, change in Valsalva LVOT gradients, and resting LVEF. Exploratory outcomes included NYHA class, KCCQ-OS, and NT-proBNP.

Participants in PIONEER-HCM had a mean age of 56 in cohort A and 58 in cohort B, were predominantly male (64% in cohort A and 50% in cohort B), and the majority were on beta-blockers prior to treatment with mavacamten (82% in cohort A and 90% in cohort B) (Table D5).

**Table D5. Selected Baseline Characteristics of PIONEER-HCM<sup>51</sup>**

	Cohort A (n=11)	Cohort B (n=10)
Age, Mean (range)	56 (22-70)	58 (26-67)
Female Gender, n (%) <sup>*</sup>	4 (36)	5 (50)
Background HOCM Therapy, n (%):		
Beta Blocker	9 (82)	9 (90)
Calcium Channel Blocker	1 (9)	0 (0)
Disopyramide	5 (45)	0 (0)
NYHA Class II, %	64	50
NYHA Class III, %	36	50
Echocardiographic Parameters:		
Interventricular Septum Thickness (SD), Mean, cm	1.7 (0.2)	1.5 (0.2)
Systolic Anterior Motion of Mitral Valve, n (%)	11 (100)	9 (90)
Left Atrial Volume Index (SD), Mean, mL/m <sup>2</sup>	30 (10)	41 (20)
Mitral Regurgitation Present, n (%)	11 (100)	10 (100)

cm: centimeter, HOCM: hypertrophic obstructive cardiomyopathy, m: meter, mL: milliliter, n: number, NYHA: New York Heart Association, SD: standard deviation

### Symptomatic Non-Obstructive HCM

MAVERICK-HCM was a Phase II multi-center, double-blind, randomized controlled trial of two doses of mavacamten compared to placebo in patients with symptomatic, non-obstructive HCM.<sup>15</sup> Fifty-nine patients were randomized to three groups: 200 ng/mL mavacamten (n=19), 500 ng/mL mavacamten (n=21) or placebo (n=19). Patients were eligible to participate if they were adults with a diagnosis of symptomatic non-obstructive HCM, defined as being NYHA function class II/III, an elevated NT-proBNP, LVEF ≥55%, and left ventricular wall thickness ≥15 mm or ≥13 mm with family history of HCM. Participants were excluded if they had resting or Valsalva and/or exercise LVOT gradient >30mm Hg. Participants were allowed to continue use of beta blockers or calcium channel blockers during the study period. Primary outcomes were safety and tolerability. Exploratory outcomes included clinical response, defined as a composite measure of 1.5 mL/kg per min or greater increase in pVO<sub>2</sub> *and* at least one NYHA class reduction *or* a 3.0 mL/kg per min or greater increase in pVO<sub>2</sub> *and* no worsening in NYHA class, pVO<sub>2</sub> change from baseline, and NYHA class.<sup>53</sup>

Participants in MAVERICK-HCM had a mean age of 58 and 50 in the mavacamten 200 ng/mL arm and 500 ng/mL arms, respectively, and 54 in the placebo arm (Table D6). The majority (62-63%) were taking beta blockers at baseline and were in NYHA class II (68-86%). Mean resting LVEF at baseline was 66-69%.

**Table D6. Selected Baseline Characteristics of MAVERICK-HCM<sup>15</sup>**

	<b>Group 1 200 ng/mL Mavacamten (n=19)</b>	<b>Group 2 500 ng/mL Mavacamten (n=21)</b>	<b>Placebo (n=19)</b>
<b>Age, Mean (SD)</b>	58 (14)	50 (15)	54 (18)
<b>Female Gender, n (%)</b>	9 (47)	12 (57)	13 (68)
<b>Background HOCM Therapy, n (%):</b>			
Beta Blocker	12 (63)	13 (62)	12 (63)
Calcium Channel Blocker	5 (26)	5 (24)	3 (16)
Neither	3 (16)	3 (14)	4 (21)
<b>NYHA Class II, %</b>	79	86	68
<b>NYHA Class III, %</b>	21	14	32
<b>Pathogenic or Likely Pathogenic HCM Gene Variant, n/N (%)</b>	7/14 (50)	7/14 (50)	8/12 (67)
<b>Echocardiographic Parameters:</b>			
LVEF, % (SD)	68 (5)	69 (6)	66 (8)
Maximal LV Wall Thickness, mm	21 (3)	20 (5)	19 (4)
Peak LVOT Gradient, mm Hg (SD)	8 (3)	9 (4)	8 (3)
<b>pVO<sub>2</sub>, Mean, mL/kg/min (SD)</b>	20 (5)	21 (7)	18 (5)
<b>NT-proBNP, Geometric Mean, pg/mL (Range)</b>	889 (747-1575)	763 (606-1261)	914 (770-1558)
<b>CTnI, Geometric Mean, ng/L (Range)</b>	0.024 (0-0.503)	0.023 (0.016-0.080)	0.02 (0.013-0.119)

CTnI: cardiac troponin I, HCM: hypertrophic cardiomyopathy, HOCM: hypertrophic obstructive cardiomyopathy, kg: kilogram, L: liter, LV: left ventricular, LVEF: left ventricular ejection fraction, LVOT: left ventricular outflow tract, mL: milliliter, mm: millimeter, mm Hg: millimeter of mercury, n: number, ng: nanogram, NT-proBNP: N-terminal pro B-type natriuretic peptide, NYHA: New York Heart Association, pg: picogram, pVO<sub>2</sub>: peak oxygen consumption, SD: standard deviation

## ***Disopyramide***

The main report discusses the primary source of data to inform our comparison of mavacamten to disopyramide, a multicenter retrospective study of observational data.<sup>29</sup> Three additional studies were identified, all single center retrospective studies.<sup>54,55</sup> One of these focused primarily on safety outcomes.<sup>35</sup>

Baseline characteristics of a multi-center retrospective study of disopyramide are provided in Table D7.

**Table D7. Selected Baseline Characteristics in Retrospective Study of Disopyramide<sup>29</sup>**

	Disopyramide (n=118)	Non-Disopyramide (n=373)
Age at Initial Evaluation, Mean (SD)	47 (20)	43 (21)
Female Gender (%)	49	47
Medical History, (%):		
Atrial Fibrillation at Initial Evaluation	20	18
Syncope or Pre-Syncope*	47	26
Dyspnea*	82	60
Septal Reduction Therapy	28	18
ICD	5	2
Background HOCM Therapy (%):		
Beta Blocker*	98	70
Calcium Channel Blocker	32	27
NYHA Class at Initial Evaluation, Mean (SD)*	2.3 (0.7)	1.9 (0.8)
LV Outflow Gradient, Mean mm Hg (SD)*	74 (35)	62 (32)

HOCM: hypertrophic obstructive cardiomyopathy, ICD: implantable cardiac device, LV: left ventricular, mm Hg: millimeter of mercury, n: number, NYHA: New York Heart Association, SD: standard deviation

\*Indicates a statistically significant difference between groups.

### ***Septal Reduction Therapies***

The main report discusses the primary source of data to inform our comparison of mavacamten to septal reduction therapies, a 2015 systematic literature review with meta-analysis of long-term outcomes of septal ablation and myectomy.<sup>30</sup> Baseline characteristics of this systematic review are provided in Table D8. A more recent systematic review with meta-analysis reported on pooled short and long-term outcomes of septal reduction therapies, primarily all-cause mortality, cardiovascular mortality, reintervention, and complications,<sup>56</sup> while another reported improvements other outcomes such as symptoms of HOCM (NYHA class) and LVOT gradient.<sup>33</sup>

**Table D8. Pooled Baseline Characteristics of Septal Reduction Therapy Studies<sup>30</sup>**

	Septal Ablation (n=2,791)	Myectomy (n=2,013)
Age, Weighted Median (IQR)*	56 (54-58)	47 (40-47)
Female Gender (%)	49.4 (45-49.4)	40.1 (37-49)
Medical History, (%):		
Syncope or Pre-Syncope (%)	16 (15-26)	21 (21-29)
ICD (%)	3 (3-5)	10 (10-10)
NYHA Class, Weighted Median (IQR)	2.8 (2.8-3)	2.9 (2.7-3.1)
LVOT Gradient, mm Hg, Weighted Median (IQR)	78 (78-104.4)	93 (67.3-103)

ICD: implantable cardioverter defibrillator, IQR: interquartile range, LVOT: left ventricular outflow tract, LVWT: left ventricular wall thickness, mm: millimeter, mm Hg: millimeter of mercury, n: number, NYHA: New York Heart Association

\*Indicates a statistically significant difference between groups.

## Effectiveness

### ***Mavacamten***

#### Symptomatic Obstructive HCM

##### *LVOT Gradients, LVEF, PVO<sub>2</sub>, and NT-proBNP*

The main report summarizes primary and secondary outcomes in the pivotal Phase III randomized controlled trial of mavacamten (EXPLORER).

In the Phase II trial (PIONEER), post-exercise, resting, and Valsalva LVOT gradients improved from baseline to week 12 in both cohort A and cohort B (Table D9). Resting LVEF declined 15% (-23 to -6) from baseline to week 12 in cohort A and 6% (-10 to -1) in cohort B. Mean pVO<sub>2</sub> increased 4 mL/kg/min (1 to 6) from baseline to week 12 in cohort A and a mean of 2 mgL/kg/min (0.03 to 3) in cohort B. Median NT-proBNP levels decreased 425 pg/mL in cohort A and 81 pg/mL in cohort B (Table D9).

**Table D9. Selected Primary, Secondary and Exploratory Outcomes of PIONEER-HCM<sup>51</sup>**

	Cohort A (n=11)	Cohort B (n=10)
Post Exercise LVOT Gradient, Mean Change from Baseline, mm Hg (SD)	-90 (-138 to -41) (n=8)	-25 (-47 to -3) (n=9)
Resting LVOT Gradient, Mean Change from Baseline, mm Hg (SD)	-48 (-72 to -23) (n=10)	-49 (-83 to -14)
Valsalva LVOT Gradient, Mean change from Baseline, mm Hg (SD)	-85 (-114 to -56) (n=10)	-47 (-82 to -12)
Resting LVEF, Mean Change from Baseline, % (SD)	-15 (-23 to -6) (n=10)	-6 (-10 to -1)
pVO <sub>2</sub> , Mean Change from Baseline, mL/kg/min (95% CI)	4 (1 to 6) (n=10)	2 (0.3 to 3)
NT-proBNP Level, Median Change from Baseline, pg/mL (IQR)	-425 (-748 to -68) (n=10)	-81 (-637 to -16) (n=9)

kg: kilogram, LVEF: left ventricular ejection fraction, LVOT: left ventricular outflow tract, mL: milliliter, mm Hg: millimeter of mercury, n: number, NT-proBNP: N-terminal pro B-type natriuretic peptide, pg: picogram, pVO<sub>2</sub>: peak oxygen consumption, SD: standard deviation

#### NYHA Class

The main report presents details on NYHA class outcomes in the pivotal Phase III randomized controlled trial of mavacamten (EXPLORER). In the Phase II trial (PIONEER), mean NYHA class declined -0.9 (-1.4 to -0.04) from baseline to week 12 in cohort A and -1.0 (-1.3 to -0.7) in cohort B.<sup>51</sup>

More detailed outcomes from both the EXPLORER and PIONEER trial are provided in Tables D19-D20.

### HRQoL

The main report provides details on HRQoL outcomes in the pivotal Phase III randomized controlled trial of mavacamten (EXPLORER).

In the Phase II trial (PIONEER), mean KCCQ overall summary score, a measure of overall health, improved 14 points (7 to 22) from baseline to 12 weeks in cohort A and 16 points (0.3 to 32) in cohort B.<sup>51</sup>

Details on HRQoL outcomes from EXPLORER and PIONEER are provided in Tables D24-D25.

### Symptomatic Non-Obstructive HCM

#### *LVEF, PVO<sub>2</sub>, and Cardiac Biomarkers*

In the Phase II trial (MAVERICK), mean LVEF decreased 2% (-5 to 0.4) from baseline to week 16 in the lower-dose mavacamten group (200 ng/mL, Group 1, n=19) and 6% (-10 to -1) in the higher-dose mavacamten group (500 ng/mL, Group 2, n=21) and 2% (-5 to 0.2) in the placebo group (n=19) (Table D10). Mean pVO<sub>2</sub> increased 0.4 mL/kg/min (-1.4 to 2) from baseline to week 16 in Group 1 and 0.1 mL/kg/min (-1.8 to 2) in Group 2 and 0.6 (-0.6 to 1.8) in the placebo group. Mean NT-proBNP decreased 47% from baseline to week 24 in Group 1, 58% in Group 2 and 0.7% in the placebo group (p=0.01 and 0.001, respectively). Mean cTnI decreased 23% from baseline to week 16 in Group 1, 41% in Group 2 and increased 4% in the placebo group (p=0.09 and 0.003, respectively) (Table D10).<sup>15</sup>

**Table D10. Change from Baseline in Selected Outcomes in the MAVERICK Trial<sup>15</sup>**

	<b>Group 1 200ng/mL Mavacamten (n=19)</b>	<b>Group 2 500ng/mL Mavacamten (n=21)</b>	<b>Placebo (n=19)</b>
<b>LVEF, Mean Change from Baseline (%) (95% CI)</b>	-2 (-5 to 0.4)	-6 (-10 to -1)	-2 (-5 to 0.2)
<b>pVO<sub>2</sub>, Mean Change from Baseline, mL/kg/min (95% CI)</b>	0.4 (-1 to 2)	0.1 (-2 to 2)	0.6 (-0.6 to 2)
<b>NT-proBNP, Geometric Mean, Change from Baseline pg/mL (%)</b>	-47	-58	-0.7
<b>cTnI, Geometric Mean, Change from Baseline ng/L (%)</b>	-23	-41	4
<b>≥1 NYHA Class Mean Change from Baseline (%) (95% CI)</b>	53 (29 to 76)	33 (15 to 57)	37 (16 to 62)
<b>Mean NYHA Class Change from Baseline (95% CI)</b>	-0.6 (-1 to -0.2)	-0.3 (-0.5 to -0.3)	-0.4 (-0.8 to -0.1)
<b>KCCQ-OSS Mean Change from Baseline (95% CI)</b>	0.4 (-5 to 5)	6 (1 to 11)	6 (-3 to 15)
<b>KCCQ-CSS Mean Change from Baseline (95% CI)</b>	0.1 (-4 to 5)	6 (1 to 10)	4 (-4 to 13)

CI: confidence interval, CTnI: cardiac troponin I, KCCQ-CS: Kansas City Cardiomyopathy Questionnaire Clinical Summary Score, KCCQ-OS: Kansas City Cardiomyopathy Questionnaire Overall Summary Score, kg: kilogram, LVEF: left ventricular ejection fraction, mL: milliliter, n: number, NT-proBNP: N-terminal pro B-type natriuretic peptide, NYHA: New York Heart Association, pVO<sub>2</sub>: peak oxygen consumption

### NYHA Class

In the MAVERICK trial, the proportion of patients who improved at least one NYHA class from baseline to week 12 was 53% in Group 1 and 33% in Group 2 and 37% in the placebo group. Mean NYHA class decreased 0.6 points (-1 to -0.2) from baseline to week 16 in Group 1, 0.3 points (-0.5 to -0.3) in Group 2, and 0.4 points (-0.8 to -0.1) in the placebo group (p=0.4 and 0.5, respectively) (Table D10).<sup>15</sup>

### HRQoL

In the MAVERICK trial, KCCQ-OS, and clinical summary score (KCCQ-CS) mean change from baseline to week 12 are shown in Table D10. Mean KCCQ-OS increased 0.4 points in Group 1, 6 points in Group 2 and 6 points in the placebo group (p=0.5 and 0.5, respectively). Mean KCCQ-CS increased 0.1 points in Group 1, 6 points in Group 2, and 4 points in the placebo group (p=1 and 0.4, respectively).<sup>15</sup>

### **Disopyramide**

The main report discusses data from the primary source of outcomes data for disopyramide, a multi-site retrospective study.<sup>29</sup> We also identified two additional single-site retrospective studies of disopyramide. In a single-site registry-based study of second-line treatments for HOCM, among



221 patients on disopyramide, mean resting gradient decreased from 63mm Hg ( $\pm 45$ ) at baseline to 25mm Hg ( $\pm 32$ ) at follow-up ( $p < 0.0001$ ). Of the 221 patients started on disopyramide, 80 (36%) underwent septal reduction over the 4.5-year study period. Among 141 patients on disopyramide who did not undergo septal reduction and remained on disopyramide, mean NYHA class decreased from 2.7 ( $\pm 0.6$ ) at initial evaluation to 1.9 ( $\pm 0.5$ ) at last evaluation ( $p < 0.0001$ ).<sup>57</sup>

In a more recent single-site retrospective study focused primarily on safety, 74 patients (44%) discontinued disopyramide due to side effects (11%) or lack of symptom improvement (33%) over a five-year period. Fifty-five patients underwent septal reduction therapy (eight septal ablation and 47 myectomy).<sup>35</sup>

### ***Septal Reduction Therapies***

The main report discusses data from the primary source of outcomes data for septal reduction therapies, a 2015 systematic review with meta-analysis.<sup>30</sup> Additional selected outcomes data from 2020 systematic review with meta-analysis was also discussed in the main report.<sup>33</sup>

## **Harms**

### ***Mavacamten***

The main report provides details on harms in the pivotal Phase III randomized controlled trial of mavacamten (EXPLORER).

In the Phase II trial (PIONEER), mavacamten was well tolerated; most adverse events were mild (80%) or moderate (19%). The most common adverse events related to mavacamten were a decrease in LVEF ( $n=3$ ) and atrial fibrillation ( $n=5$ ). One patient in cohort A experienced a serious adverse event (atrial fibrillation leading to hospitalization) and discontinued treatment.<sup>51</sup>

Details on adverse events from EXPLORER and PIONEER are provided in Tables D27-D28.

### ***Disopyramide***

The main report discusses adverse events from the primary sources of data for harms of disopyramide, a multi-center retrospective study as well as a single-site retrospective study focused on safety.<sup>29,35</sup>

### ***Septal Reduction Therapies***

The main report discusses adverse events from the primary source of data for septal reduction therapies.<sup>30</sup>

## Subgroup Analyses and Heterogeneity

The main report discusses available subgroup analyses in the setting of obstructive HCM.

The data on mavacamten in the setting of symptomatic non-obstructive HCM is substantially weaker compared to in the setting of symptomatic obstructive HCM. Improvements in cardiac biomarkers such as NT-proBNP and cTnI with mavacamten in the MAVERICK trial in patients with non-obstructive HCM point to potential benefits of the drug, but improvements in patient-important outcomes such as NYHA class or HRQoL were not observed although the study was not adequately powered for these clinical endpoints.<sup>15</sup>

## Uncertainties and Controversies

The MAVERICK-HCM trial (discussed in Section D2) is a Phase II trial that enrolled 59 patients and assessed the effectiveness of mavacamten in non-obstructive HCM patients. Although the trial did not demonstrate a difference in an exploratory composite functional endpoint that includes symptoms, identical to the primary endpoint in EXPLORER-HCM, there were improvements in biomarkers including NT-proBNP and troponin. Non-obstructive symptomatic HCM patients have fewer alternatives for reducing symptoms, since there is not a conceptual basis to support therapies directed at reducing the LVOT gradient. As such, clinicians and patients may use mavacamten to reduce symptoms in non-obstructive HCM patients simply on the conceptual basis of reducing wall stress, even if this indication is not within the FDA label for mavacamten. Phase III trials that are statistically powered for clinical outcomes could assess the effectiveness of mavacamten for symptomatic HCM patients without obstruction.

## D3. Evidence Tables

Table D11. Study Quality Table<sup>15,24</sup>

Trial	Comparable Groups	Non-Differential Follow-Up	Patient/ Investigator Blinding	Clear Definition of Intervention	Clear Definition of Outcomes	Selective Outcome Reporting	Measurements Valid	Intention-to-Treat Analysis	Approach to Missing Data	USPSTF Rating
<b>Population: Symptomatic Obstructive HCM</b>										
<b>EXPLORER-HCM</b>	Yes, with exception to gender, AF rates, and mean NT-proBNP	Yes	Yes	Yes	Yes	No	Yes	Yes	NRI for primary composite endpoint; week 26 timepoint used for NYHA if week 30 endpoint was missing	Good
<b>Population: Symptomatic Non-Obstructive HCM</b>										
<b>MAVERICK-HCM</b>	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	NR	Good

AF: atrial fibrillation, HCM: hypertrophic cardiomyopathy, NR: not reported, NRI: non-responder imputation, NT-proBNP: N-terminal pro B-type natriuretic peptide, NYHA: New York Heart Association, USPSTF: United States Preventive Services Task Force

**Table D12. Study Design: Mavacamten**<sup>1,15,24,27,34,51,52,58-60</sup>

Trial (NCT)	Study Design & Location	N	Treatment	Inclusion & Exclusion Criteria	Key Outcomes
<b>Symptomatic Obstructive HCM</b>					
EXPLORER-HCM  NCT03470545	Phase III DB, PC, RCT, MC  Location: global	N=251 Patients ages 18+ with symptomatic HOCM	Individualized doses of 2.5, 5, 10, or 15 mg (n=123) or placebo (n=128) administered orally  30-week treatment	<u>Inclusion Criteria</u> <ul style="list-style-type: none"> <li>• Age 18 and greater, body weight <math>\geq 45</math> kg</li> <li>• Has adequate acoustic windows to enable accurate TTEs</li> <li>• Diagnosed with HOCM consistent with current ACCF/AHA and European Society of Cardiology guidelines and has documented LVEF <math>\geq 55\%</math> and NYHA class II or III</li> <li>• Has documented O<sub>2</sub> saturation at rest <math>\geq 90\%</math> at screening</li> <li>• Able to perform an upright CPET and has a respiratory exchange ratio (RER) <math>\geq 1.0</math> at screening per central reading</li> </ul> <u>Exclusion Criteria</u> <ul style="list-style-type: none"> <li>• Cardiac hypertrophy that mimics HOCM</li> <li>• History of syncope or sustained V-tach with exercise, resuscitated sudden cardiac arrest or ICD discharge for life-threatening ventricular arrhythmia within 6 months</li> <li>• Has paroxysmal, intermittent AF or persistent or permanent AF not on anticoagulation for at least 4 weeks and/or not controlled within 1 year</li> <li>• Treatment with disopyramide or ranolazine</li> <li>• Any dose adjustment of <math>\beta</math>-blockers, verapamil, or diltiazem treatment</li> <li>• Has LVOT gradient with Valsalva maneuver <math>&lt; 30</math> mm Hg</li> <li>• Has been successfully treated with invasive septal reduction (surgical myectomy or septal ablation) within 6 months</li> <li>• ICD placement within 6 months</li> <li>• Has pulmonary disease that limits exercise capacity or systemic arterial oxygen saturation</li> <li>• Prior treatment with cardiotoxic agents such as doxorubicin or similar</li> </ul>	Percentage of Participants Achieving A Clinical Response: <u>Primary:</u> <ul style="list-style-type: none"> <li>• 1.5 mL/kg per min or greater increase in pVO<sub>2</sub> and at least one NYHA class reduction or a 3.0 mL/kg per min or greater pVO<sub>2</sub> increase without NYHA class worsening</li> </ul> <u>Secondary:</u> <ul style="list-style-type: none"> <li>• Change in post-exercise LVOT gradient</li> <li>• Change in pVO<sub>2</sub></li> <li>• Change in NYHA class</li> <li>• Change in KCCQ-CSS</li> <li>• Change in HCMSQ-SoB</li> </ul>

Trial (NCT)	Study Design & Location	N	Treatment	Inclusion & Exclusion Criteria	Key Outcomes
MAVA-LTE NCT03723655	Phase III Long-term extension trial  Location: global	Patients ages 18+ who completed either MAVERICK- HCM or EXPLORER- HCM trials	Mavacamten 5 mg/d, with dose adjustments (2.5, 5, 10, or 15 mg) at weeks 4, 8, and 12 if needed	<u>Inclusion Criteria</u> <ul style="list-style-type: none"> <li>Patients who successfully complete either MyoKardia's MAVERICK-HCM or EXPLORER-HCM clinical trials</li> <li>Has a body weight greater than 45 kg</li> <li>Has adequate acoustic windows to enable accurate TTEs</li> <li>Has documented LVEF <math>\geq</math> 50% by echocardiography core laboratory read of screening TTE at rest</li> <li>Has safety laboratory parameters (chemistry, hematology, coagulation, and urinalysis) within normal limits</li> </ul> <u>Exclusion Criteria</u> <ul style="list-style-type: none"> <li>Has any ECG abnormality that poses a risk to participant safety</li> <li>Has a history of syncope or a history of sustained ventricular tachycardia with exercise between Parent Study EOS Visit and screening visit</li> <li>Has a history of resuscitated sudden cardiac arrest or known history of appropriate ICD discharge for life-threatening ventricular arrhythmia between Parent Study EOS Visit and screening visit</li> <li>Currently or planned treatment with disopyramide or ranolazine</li> <li>Has any acute or serious comorbid condition (e.g., major infection or hematologic, renal, metabolic, GI, or endocrine dysfunction) that could interfere with study</li> <li>History of clinically significant malignant disease that developed since enrollment in the Parent Study.</li> <li>Has participated in a clinical trial with any investigational drug, except for MAVERICK-HCM or EXPLORER-HCM</li> </ul>	<u>Primary:</u> Frequency and severity of TEAS and SAEs (252 weeks)

Trial (NCT)	Study Design & Location	N	Treatment	Inclusion & Exclusion Criteria	Key Outcomes
PIONEER-HCM  NCT02842242  Heitner 2021	Phase II open-label, MC, pilot study  Location: U.S.	N=21 Patients ages 18-70 with symptomatic HCM and LVOT obstruction	Cohort A: Mavacamten 10 to 20 mg/d, without background medications  Cohort B: Mavacamten 2 to 5 mg/d, with $\beta$ -blockers allowed  12-week treatment	<u>Inclusion Criteria</u> <ul style="list-style-type: none"> <li>Diagnosed with HCM, with LV wall thickness <math>\geq 15</math> mm at time of initial diagnosis or <math>\geq 13</math> mm with a positive family history of HCM</li> <li>Age 18-70</li> <li>BMI 18-37 kg/m<sup>2</sup></li> <li>Documented LVEF <math>\geq 55\%</math> at the screening visit as determined by the investigator and the investigational site's echocardiography laboratory</li> <li>Resting LVOT gradient <math>\geq 30</math> mm Hg and post-exercise peak LVOT gradient <math>\geq 50</math> mm Hg</li> </ul> NYHA functional class II or higher  <u>Exclusion Criteria</u> <ul style="list-style-type: none"> <li>History of sustained V-tach or syncope with exercise</li> <li>Active infection</li> <li>Persistent AF or AF at screening or history of paroxysmal AF with resting rate document <math>&gt; 100</math> bpm within 1 year of screening</li> <li>Has QTc Fridericia (QTcF) <math>&gt; 500</math> ms, or any other ECG abnormality considered by the investigator to pose a risk to subject safety</li> <li>Aortic stenosis or fixed subaortic obstruction</li> <li>History of LV systolic dysfunction (LVEF <math>&lt; 45\%</math>) at any time during their clinical course</li> <li>History of obstructive coronary artery disease</li> <li>Part A: Ongoing therapy with beta blockers, calcium channel blockers, or disopyramide</li> <li>Part B: Ongoing therapy with calcium channel blockers or disopyramide</li> <li>Prior treatment with cardiotoxic agents such as doxorubicin or similar, or current treatment with antiarrhythmic drugs that have negative inotropic activity, e.g., flecainide or propafenone.</li> </ul>	<u>Primary:</u> <ul style="list-style-type: none"> <li>Change in post-exercise peak LVOT gradient from baseline to Week 12</li> </ul> <u>Secondary:</u> <ul style="list-style-type: none"> <li>Change in dyspnea symptom score from baseline to week 12</li> <li>Change in LVEF 2D and 3D, global longitudinal strain, and LV fractional shortening from baseline to week 12</li> <li>Change in post-exercise peak LVOT gradient from week 12 to week 16</li> <li>Change in pVO<sub>2</sub> and VE/VCO<sub>2</sub> from baseline to week 12</li> <li>Plasma PK profile of mavacamten (16 weeks)</li> <li>Proportion of subjects achieving an LVOT gradient response of post-exercise peak gradient <math>&lt; 30</math> mm Hg (12 weeks)</li> </ul>

Trial (NCT)	Study Design & Location	N	Treatment	Inclusion & Exclusion Criteria	Key Outcomes
PIONEER-OLE NCT03496168	Phase II, ongoing 3-year prospective, open-label, multicenter study  Location: US	N=13 Patients ages 18+ with symptomatic HOCM previously enrolled in PIONEER-HCM	starting dose: 5 mg/d; titration at Week 6 to an individualized dose (5, 10, or 15 mg)	<u>Inclusion Criteria</u> <ul style="list-style-type: none"> <li>Completed Study MYK-461-004</li> <li>-Body weight &gt; 45 kg</li> <li>Has safety laboratory parameters (chemistry and hematology) within normal limits</li> </ul> <u>Exclusion Criteria</u> <ul style="list-style-type: none"> <li>Has QTcF &gt;480 ms or any other ECG abnormality</li> <li>Since enrollment into Study MYK-461-004, has developed obstructive coronary artery disease or known moderate or severe aortic valve stenosis</li> <li>Since enrollment into Study MYK-461-004, has developed any acute or serious comorbid condition (e.g., major infection or hematologic, renal, metabolic, GI, or endocrine dysfunction)</li> <li>Has a positive serologic test at Screening for human immunodeficiency virus, hepatitis C virus, or hepatitis B virus</li> <li>Since enrollment into Study MYK-461-004 has developed clinically significant malignant disease</li> </ul>	Frequency and severity of adverse events: <ul style="list-style-type: none"> <li>LVOT Gradient</li> <li>E/e at Week 24</li> <li>LA Volume Index (LAVi) at Week 24</li> <li>NT-proBNP at Week 24</li> <li>Interventricular Septal Thickness (IST) at Week 24</li> <li>LVEF at Week 24</li> <li>NYHA Class Improvement</li> </ul>
<b>Symptomatic Non-Obstructive HCM</b>					
MAVERICK-HCM NCT03442764	Phase 2 DB, MC, PC, RCT  Location: US	N=59 Patients ages 18+ with body weight ≥45 kg with symptomatic non-OHCM and preserved LVEF	Group 1: Starting dose mavacamten 5 mg/d, adjusted at week 6 (2.5, 5, 10, or 15 mg) according to 200 ng/mL target PK  Group 2: Starting dose	<u>Inclusion Criteria</u> <ul style="list-style-type: none"> <li>Diagnosed with HCM (hypertrophied and non-dilated left ventricle in absence of systemic or other known cause), with LV wall thickness ≥15 mm at Screening or ≥13 mm with a positive family history of HCM.</li> <li>Age 18 and greater, body weight ≥45 kg</li> <li>Documented LVEF ≥55% at Screening</li> <li>LVOT gradient &lt;30 mm Hg</li> <li>NYHA functional class II or III</li> <li>Elevated NT-proBNP at rest</li> </ul> <u>Exclusion Criteria</u> <ul style="list-style-type: none"> <li>History of syncope, sustained ventricular tachycardia with exercise, resuscitated sudden cardiac arrest or ICD discharge</li> </ul>	<u>Primary:</u> <ul style="list-style-type: none"> <li>Safety and tolerability at Week 16 (AEs, TEAEs, etc.)</li> </ul> <u>Exploratory Endpoints at Week 16:</u> <ul style="list-style-type: none"> <li>Composite functional endpoint (1.5 mL/kg per min or greater increase in peak oxygen consumption (pVO<sub>2</sub>) and at least one NYHA class</li> </ul>

Trial (NCT)	Study Design & Location	N	Treatment	Inclusion & Exclusion Criteria	Key Outcomes
			mavacamten 5 mg/d, adjusted at week 6 (2.5, 5, 10, of 15 mg) according to 500 ng/mL target PK  Placebo	<ul style="list-style-type: none"> <li>Has AF at Screening</li> <li>Treatment with disopyramide, a combination of beta blockers and verapamil or combination of beta blockers and diltiazem</li> <li>Has been treated with invasive septal reduction (surgical myectomy or septal ablation) within 6 months</li> <li>Resting or post-exercise LVOT &gt;30mm Hg unless treated by septal reduction</li> <li>Has QTc Fridericia (QTcF) &gt;480 ms or any other ECG abnormality considered to pose a risk to participant safety</li> <li>History of obstructive coronary artery disease or myocardial infarction within past 6 months</li> <li>Has pulmonary disease that limits exercise capacity or systemic arterial oxygen saturation</li> </ul>	reduction or a 3.0 mL/kg per min or greater pVO <sub>2</sub> increase without NYHA class worsening) <ul style="list-style-type: none"> <li>pVO<sub>2</sub> change from baseline</li> </ul>

3D: three-dimensional, AF: atrial fibrillation, AE: adverse event, ACCF: American College of Cardiology Foundation, AHA: American Heart Association, CPET: cardiopulmonary exercise testing, d: day, DB: double-blind, ECG: electrocardiogram, EOS: end of study, HCM: hypertrophic cardiomyopathy, HOCM: hypertrophic obstructive cardiomyopathy, ICD: implantable cardioverter-defibrillator, KCCQ-CSS: Kansas City Cardiomyopathy Questionnaire Clinical Summary Score, kg: kilogram, LV: left ventricular, LVEF: left ventricular ejection fraction, LVOT: left ventricular outflow tract, m: meter, MC: multi-center, mg: milligram, mL: milliliter, mm: millimeter, mm Hg: millimeter of mercury, ms: millisecond, n: number, NCT: National Clinical Trial number, NT-proBNP: N-terminal pro B-type natriuretic peptide, NYHA: New York Heart Association, O<sub>2</sub>: oxygen, PC: placebo-controlled, PK: pharmacokinetic, pVO<sub>2</sub>: peak oxygen consumption, RCT: randomized controlled trial, RER: respiratory exchange ratio, TTE: transthoracic echocardiogram, VE: ventilation, VCO<sub>2</sub>: volume of exhaled carbon dioxide



**Table D13. Study Design: Comparators<sup>29,30</sup>**

Trial & Author	Study Design & Location	N	Treatment	Inclusion & Exclusion Criteria	Key Outcomes
<b>Disopyramide</b>					
Sherrid et al. 2005	Retrospective, multicenter, observational study  Location: US, Poland, UK	N=491  Patients with HOCM	Disopyramide with initial dose of 200 or 250 mg/day and dose adjustments every 2 weeks if needed (n=118)  No disopyramide treatment (n=373)	<u>Inclusion Criteria</u> <ul style="list-style-type: none"> <li>Patients with HCM consecutively treated at one of the four HCM centers from 1990-1999</li> <li>Outflow obstruction at rest (gradient <math>\geq 30</math> mm Hg)</li> </ul> <u>Exclusion Criteria</u> NR	<ul style="list-style-type: none"> <li>Need for non-pharmacologic intervention (e.g., septal reduction therapy and pacing)</li> <li>LVOT gradient at rest</li> <li>Mean NYHA functional class</li> <li>Mortality rates</li> </ul>
<b>Septal Reduction Therapy (Septal Myectomy and Septal Ablation)</b>					
Liebrechts et al. 2015	Systematic literature review of studies looking at septal ablation or septal myectomy in HCM patients  Location: Varies	N=4,804 (24 studies)  Patients with HOCM undergoing septal ablation or septal myectomy	Septal ablation (n=2,013; 11 cohorts)  Septal myectomy (n=2,791; 16 cohorts)	<u>Inclusion Criteria for Studies</u> <ul style="list-style-type: none"> <li>Having at least 5 HOCM patients undergoing septal ablation and/or septal myectomy</li> <li>Mean follow-up at least 5 years</li> </ul> <u>Exclusion Criteria for Studies</u> <ul style="list-style-type: none"> <li>Other ablative media than ethanol</li> <li>Enrollment of primarily patients who underwent rescue ablation or rescue myectomy after failed previous septal reduction therapy</li> <li>Enrollment of primarily patients who underwent combined procedures, have a high risk of sudden death, or children</li> </ul>	<u>Short-term outcomes:</u> <ul style="list-style-type: none"> <li>Mortality rates</li> <li>Necessity of pacemaker implantation</li> <li>AEs</li> </ul> <u>Long-term outcomes</u> <ul style="list-style-type: none"> <li>Mortality rates</li> <li>AEs</li> <li>LVOT gradient reduction</li> <li>NYHA class reduction</li> <li>Need for reintervention</li> </ul>

AE: adverse events, d: day, HOCM: hypertrophic obstructive cardiomyopathy, HCM: hypertrophic cardiomyopathy, LVOT: left ventricular outflow gradient, mg: milligram, mm Hg: millimeter of mercury, n: number, N: total number, NR: not reported, NYHA: New York Heart Association

**Table D14. Baseline Characteristics: Phase III Trials<sup>24,27</sup>**

Trial		EXPLORER-HCM		MAVA-LTE (EXPLORER-HCM Cohort)
Arms		Mavacamten	Placebo	Mavacamten
N		123	128	224
Age, Mean (SD)		58.5 (12.2)	58.5 (11.8)	60.3 (11.8)
Sex, n (%)	Men	66 (54)	83 (65)	135 (60.3)
	Women	57 (46)	45 (35)	89 (39.7)
Race, n (%)	White	115 (93)	114 (89)	NR
	Black or African American	1 (1)	5 (4)	NR
	Native American or Alaskan Native	0	1 (1)	NR
	Asian	4 (3)	2 (2)	NR
	Unknown	3 (2)	6 (5)	NR
Region, n (%)	USA	53 (43)	55 (43)	NR
	Spain	17 (14)	16 (13)	NR
	Poland	16 (13)	16 (13)	NR
	Other	37 (30)	41 (32)	NR
BMI, Mean kg/m <sup>2</sup> (SD)		29.7 (4.9)	29.2 (5.6)	NR
Heart Rate, Mean bpm (SD)		63 (10.1)	62 (10.6)	NR
Blood Pressure, Mean mm Hg (SD)	Systolic Blood Pressure	128 (16.2)	128 (14.6)	NR
	Diastolic Blood Pressure	75 (10.8)	76 (9.9)	NR
NYHA Functional Class, n (%)	Class I	NA	NA	13 (5.8)
	Class II	88 (72)	95 (74)	146 (65.2)
	Class III	35 (28)	33 (26)	65 (29)
Mavacamten Dose Assignment, n (%)	2 mg/d	NA	NA	NR
	5 mg/d	123 (100)	NA	NR
	10 mg/d (≤60 kg), 15 mg/d if (60 kg)	NA	NA	NR
pVO <sub>2</sub> , Mean mL/kg per Min (SD)		18.9 (4.9)	19.9 (4.9)	NR
HCM Genetic Testing Performed, n (%)		90 (73)	100 (78)	NR
Pathogenic or Likely Pathogenic HCM Gene Variant, n/N (%)		28/90 (31)	22/100 (22)	NR
Medical History, n (%)	Family History of HCM	33 (27)	36 (28)	NR
	Atrial Fibrillation	12 (10)	23 (18)	NR
	Septal Reduction Therapy	11 (9)	8 (6)	NR
	Hypertension	57 (46)	53 (41)	NR
	Hyperlipidemia	27 (22)	39 (30)	NR
	Coronary Artery Disease	12 (10)	6 (5)	NR

Trial		EXPLORER-HCM		MAVA-LTE (EXPLORER-HCM Cohort)
Arms		Mavacamten	Placebo	Mavacamten
N		123	128	224
	Obesity	15 (12)	14 (11)	NR
	Type 2 Diabetes	6 (5)	7 (6)	NR
	Asthma	17 (14)	11 (9)	NR
	Chronic Obstructive Pulmonary Disease	2 (2)	3 (2)	NR
Background HCM Therapy, n (%)	B-blocker	94 (76)	95 (74)	169 (75.4)
	Calcium Channel Blocker	25 (20)	17 (13)	37 (16.5)
	Neither B-blocker nor Calcium Channel Blocker	4 (3)	16 (13)	NR
	Disopyramide	NA	NA	NR
NT-proBNP, Geometric Mean, ng/L (CV%)		777 (136)	616 (108)	Median: 785* IQR: 323 to 1586
High-Sensitivity Cardiac Troponin I, Geometric Mean, ng/L (CV%)		12.5 (208)	12.5 (373)	NR
KCCQ OSS, Mean (SD)		NR	NR	NR
NRS Dyspnea, Mean (SD)		NR	NR	NR
VE/VCO <sub>2</sub> , Mean (SD)		NR	NR	NR
Echocardiographic Parameters	LVEF Mean, % (SD)	74 (6)	74 (6)	74 (5.9)
	Resting LVEF Mean, % (SD)	NR	NR	NR
	Exercise LVEF Mean, % (SD)	NR	NR	NR
	Maximum LV Wall Thickness, Mean mm (SD)	20 (4)	20 (3)	NR
	LVOT Gradient, Rest, Mean mm Hg (SD)	52 (29)	51 (32)	48.1 (31.6)
	LVOT Gradient, Valsalva, Mean mm Hg (SD)	72 (32)	74 (32)	69.5 (33.2)†
	LVOT Gradient, Post-Exercise, Mean mm Hg (SD)	86 (34)	84 (36)	NR
	Interventricular Septum Thickness, Mean cm (SD)	NR	NR	NR
	Systolic Anterior Motion of Mitral Valve, n (%)	NR	NR	NR
	LAVI, Mean mL/m <sup>2</sup> (SD)	40 (12)	41 (14)	37.9 (12.5)‡
	Mitral Regurgitation Present, n (%)	NR	NR	NR
	Left Atrial Diameter, Mean mm (SD)	42 (5)	42 (6)	NR

bpm: beats per minute, cm: centimeter, d: day, HCM: hypertrophic cardiomyopathy, KCCQ-OSS: Kansas City Cardiomyopathy Questionnaire Overall Summary Score, kg: kilogram, L: liter, LAVI: left atrial volume index, LV: left ventricular, LVEF: left ventricular ejection fraction, LVOT: left ventricular outflow tract, m: meter, mg: milligram, mL: milliliter, mm: millimeter, mm Hg: millimeter of mercury, n: number, N: total number, NA: not applicable, NR: not reported, NRS: numerical rating scale, NT-proBNP: N-terminal pro B-type natriuretic peptide, NYHA: New York Heart Association, pVO<sub>2</sub>: peak oxygen consumption, VE: ventilation, VCO<sub>2</sub>: volume of exhaled carbon dioxide, SD: standard deviation

\*N=223, †N=221, ‡N=216

**Table D15. Baseline Characteristics: Phase II Trials<sup>51,52,58-60</sup>**

Trial		PIONEER-HCM		PIONEER-OLE		
Arms		Cohort A	Cohort B	Cohort A	Cohort B	Mavacamten (Overall)
N		11	10	5	8	13
Age, Mean (SD)		56, range: 22-70	58, range: 26-67	NR	NR	57.8
Sex, n (%)	Men	7 (64)	5 (50)	NR	NR	9 (69.2)
	Women	4 (36)	5 (50)	NR	NR	4 (31.8)
Race, n (%)	White	11 (100)	9 (90)	NR	NR	NR
	Black or African American	0	1 (10)	NR	NR	NR
	Native American or Alaskan Native	0	0	NR	NR	NR
	Asian	0	0	NR	NR	NR
	Unknown	0	0	NR	NR	NR
Region, n (%)	USA	11 (100)	12 (100)	NR	NR	NR
	Spain	0	0	NR	NR	NR
	Poland	0	0	NR	NR	NR
	Other	0	0	NR	NR	NR
BMI, Mean kg/m <sup>2</sup> (SD)		29.7 (4.1)	32.3 (5.4)	NR	NR	NR
Heart Rate, Mean bpm (SD)		76 (10)	62 (8)	NR	NR	NR
Blood Pressure, Mean mm Hg (SD)	Systolic Blood Pressure	136 (13)	132 (14)	NR	NR	NR
	Diastolic Blood Pressure	75 (8)	77 (15)	NR	NR	NR
NYHA Functional Class, n (%)	Class I	NA	NA	NR	NR	NR
	Class II	7 (64)	5 (50)	NR	NR	NR
	Class III	4 (36)	5 (50)	NR	NR	NR
Mavacamten Dose Assignment, n (%)	2 mg/d	NA	10 (100)	NR	NR	NR
	5 mg/d	NA	NA	NR	NR	NR
	10 mg/d (≤60 kg), 15 mg/d if (60 kg)	11 (100)	NA	NR	NR	NR
pVO <sub>2</sub> , Mean mL/kg per min (SD)		20.7 (7.4)	19.4 (4.6)	NR	NR	NR
HCM Genetic Testing Performed, N (%)		NR	NR	NR	NR	NR
Pathogenic or Likely Pathogenic HCM Gene Variant, n/N (%)		5/21 (23.8)		NR	NR	NR
Medical History, n (%)	Family History of HCM	NR	NR	NR	NR	NR
	Atrial Fibrillation	NR	NR	NR	NR	NR
	Septal Reduction Therapy	NR	NR	NR	NR	NR
	Hypertension	NR	NR	NR	NR	NR
	Hyperlipidemia	NR	NR	NR	NR	NR
	Coronary Artery Disease	NR	NR	NR	NR	NR
	Obesity	NR	NR	NR	NR	NR
	Type 2 Diabetes	NR	NR	NR	NR	NR
	Asthma	NR	NR	NR	NR	NR
	Chronic Obstructive Pulmonary Disease	NR	NR	NR	NR	NR

Trial		PIONEER-HCM		PIONEER-OLE		
Arms		Cohort A	Cohort B	Cohort A	Cohort B	Mavacamten (Overall)
N		11	10	5	8	13
Background HCM Therapy, n (%)	B-Blocker	9 (82)	9 (90)	NR	NR	12 (92.3)
	Calcium Channel Blocker	1 (9)	0 (0)	NR	NR	NR
	Neither B-blocker nor Calcium Channel Blocker	NR	NR	NR	NR	NR
	Disopyramide	5 (45)	0 (0)	NR	NR	NR
NT-proBNP, Geometric Mean, pg/mL (SD)		930 (647)	1834 (3209)*	NR	NR	1836 (2886)
High-Sensitivity Cardiac Troponin I, Geometric Mean, ng/L (CV%)		NR	NR	NR	NR	NR
KCCQ OSS, Mean (SD)		65 (16)	61 (26)	NR	NR	74.1 (18.4)
NRS Dyspnea, Mean (SD)		4.9 (1.6)	4.0 (2.6)	NR	NR	NR
VE/VCO <sub>2</sub> , Mean (SD)		32.2 (5.4)	32.3 (4.4)	NR	NR	NR
Echocardiographic Parameters	LVEF Mean, % (SD)	NR	NR	69.4 (5.6 <sup>†</sup> )	73.6 (3.8 <sup>†</sup> )	72 (4.9)
	Resting LVEF Mean, % (SD)	70 (7)	75 (5)	NR	NR	NR
	Exercise LVEF Mean, % (SD)	76 (8)	76 (8)	NR	NR	NR
	Maximum LV Wall Thickness, Mean mm (SD)	NR	NR	NR	NR	11.7 (2.2) <sup>‡</sup>
	LVOT Gradient, Rest, Mean mm Hg (SD)	60 (28)	86 (63)	NR	NR	67.3 (42.8)
	LVOT Gradient, Valsalva, Mean mm Hg (SD)	97 (32)	100 (65)	75.7 (30.7 <sup>†</sup> ) <sup>¶</sup>	97 (29.7 <sup>†</sup> )	89.9 (30.7)
	LVOT Gradient, Post-Exercise, Mean mm Hg (SD)	103 (50)*	86 (43)*	NR	NR	127.5 (33.4) <sup>#</sup>
	Interventricular Septum Thickness, Mean cm (SD)	1.7 (0.2)	1.5 (0.2)	NR	NR	16.7 (2.8)
	Systolic Anterior Motion of Mitral Valve, n (%)	11 (100)	9 (90)	NR	NR	NR
	LAVI, Mean mL/m <sup>2</sup> (SD)	30 (10)	41 (20)	NR	NR	40.9 (16.4)
	Mitral Regurgitation Present, n (%)	11 (100)	10 (100)	NR	NR	NR
	Left Atrial Diameter, Mean mm (SD)	NR	NR	NR	NR	NR

bpm: beats per minute, cm: centimeter, d: day, HCM: hypertrophic cardiomyopathy, KCCQ-OSS: Kansas City Cardiomyopathy Questionnaire Overall Summary Score, kg: kilogram, L: liter, LAVI: left atrial volume index, LV: left ventricular, LVEF: left ventricular ejection fraction, LVOT: left ventricular outflow tract, m: meter, mg: milligram, mL: milliliter, mm: millimeter, mm Hg: millimeter of mercury, n: number, N: total number, NA: not applicable, NR: not reported, NRS: numerical rating scale, NT-proBNP: N-terminal pro B-type natriuretic peptide, NYHA: New York Heart Association, pg: picogram, pVO<sub>2</sub>: peak oxygen consumption, VE: ventilation, VCO<sub>2</sub>: volume of exhaled carbon dioxide, SD: standard deviation

\*N=9, <sup>†</sup>Digitized estimate, <sup>‡</sup>LV posterior wall thickness, <sup>¶</sup>N=4, <sup>#</sup>N=12

Table D16. Baseline Characteristics: MAVERICK-HCM<sup>15</sup>

Trial		MAVERICK-HCM			
Arms		Group 1 Mava (~200 ng/mL)	Group 2 Mava (~500 ng/mL)	Pooled Mavacamten	Placebo
N		19	21	40	19
Age, Mean (SD)		58.3 (13.7)	50.0 (14.7)	54.0 (14.6)	53.8 (18.2)
Sex, n (%)	Men	10 (52.6)	9 (42.9)	19 (47.5)	6 (31.6)
	Women	9 (47.4)	12 (57.1)	21 (52.5)	13 (68.4)
Race, n (%)	White	17 (89.5)	18 (85.7)	35 (87.5)	17 (89.5)
	Black or African American	1 (5.3)	1 (4.8)	2 (5.0)	0
	Native American or Alaskan Native	NR	NR	NR	NR
	Asian	1 (5.3)	0	1 (2.5)	0
	Unknown	0	2 (9.5)	2 (5.0)	2 (10.5)
Region, n (%)	USA	19 (100)	21 (100)	40 (100)	19 (100)
	Spain	NR	NR	NR	NR
	Poland	NR	NR	NR	NR
	Other	NR	NR	NR	NR
BMI, Mean kg/m <sup>2</sup> (SD)		28.8 (4.1)	29.8 (6.1)	29.3 (5.2)	31.0 (4.9)
Heart Rate, Mean bpm (SD)		NR	NR	NR	NR
Blood Pressure, Mean mm Hg (SD)	Systolic Blood Pressure	NR	NR	NR	NR
	Diastolic Blood Pressure	NR	NR	NR	NR
NYHA Functional Class, n (%)	Class I	NA	NA	NA	NA
	Class II	15 (78.9)	18 (85.7)	33 (82.5)	13 (68.4)
	Class III	4 (21.1)	3 (14.3)	7 (17.5)	6 (31.6)
Mavacamten Dose Assignment, n (%)	2 mg/d	NA	NA	NA	NA
	5 mg/d	19 (100)	21 (100)	40 (100)	NA
	10 mg/d (≤60 kg), 15 mg/d if (60 kg)	NA	NA	NA	NA
pVO <sub>2</sub> , Mean mL/kg per Min (SD)		19.5 (5.2)	21 (6.6)	20.4 (6)	17.9 (5.1)
HCM Genetic Testing Performed, n (%)		14 (73.7)	14 (66.7)	28 (70.0)	12 (63.2)
Pathogenic or Likely Pathogenic HCM Gene Variant, n/N (%)*		7/14 (50.0)	7/14 (50.0)	14/28 (50.0)	8/12 (66.7)
Medical History, n (%)	Family History of HCM	NR	NR	NR	NR
	Atrial Fibrillation	NR	NR	NR	NR
	Septal Reduction Therapy	NR	NR	NR	NR
	Hypertension	NR	NR	NR	NR
	Hyperlipidemia	NR	NR	NR	NR
	Coronary Artery Disease	NR	NR	NR	NR
	Obesity	NR	NR	NR	NR

Trial		MAVERICK-HCM			
Arms		Group 1 Mava (~200 ng/mL)	Group 2 Mava (~500 ng/mL)	Pooled Mavacamten	Placebo
N		19	21	40	19
	Type 2 Diabetes	NR	NR	NR	NR
	Asthma	NR	NR	NR	NR
	Chronic Obstructive Pulmonary Disease	NR	NR	NR	NR
Background HCM Therapy, n (%)	B-Blocker	12 (63.2)	13 (61.9)	25 (62.5)	12 (63.2)
	Calcium Channel Blocker	5 (26.3)	5 (23.8)	10 (25)	3 (15.8)
	Neither B-Blocker nor Calcium Channel Blocker	3 (15.8)	3 (14.3)	6 (15)	4 (21.1)
	Disopyramide	NR	NR	NR	NR
NT-proBNP, Geometric Mean, pg/mL (95% CI)		889 (747 to 1,575)	763 (606 to 1,261)	821 (790 to 1,293)	914 (770 to 1,558)
High-Sensitivity Cardiac Troponin I, Geometric Mean, ng/mL (95% CI)		0.024 (0 to 0.503)	0.023 (0.016 to 0.08)	0.023 (0 to 0.253)	0.02 (0.013 to 0.119)
KCCQ OSS, Mean (SD)		NR	NR	NR	NR
NRS Dyspnea, Mean (SD)		NR	NR	NR	NR
VE/VCO <sub>2</sub> , Mean (SD)		NR	NR	NR	NR
Echocardiographic Parameters	LVEF Mean, % (SD)	68 (5.2)	69.4 (5.8)	68.7 (5.5)	66.4 (7.7)
	Resting LVEF Mean, % (SD)	NR	NR	NR	NR
	Exercise LVEF Mean, % (SD)	NR	NR	NR	NR
	Maximum LV Wall Thickness, Mean mm (SD)	20.9 (3)	20.4 (4.8)	20.6 (4)	18.8 (3.5)
	LVOT Gradient, Rest, Mean mm Hg (SD)	8.1 (3.3)	9.4 (3.6)	8.8 (3.5)	7.8 (2.5)
	LVOT Gradient, Valsalva, Mean mm Hg (SD)	NR	NR	NR	NR
	LVOT Gradient, Post-Exercise, Mean mm Hg (SD)	NR	NR	NR	NR
	Interventricular Septum Thickness, Mean cm (SD)	NR	NR	NR	NR
	Systolic Anterior Motion of Mitral Valve, n (%)	NR	NR	NR	NR
	LAVI, Mean mL/m <sup>2</sup> (SD)	40.3 (16.1)	34.5 (8.9)	37.3 (13)	40.8 (15.2)
	Mitral Regurgitation Present, n (%)	NR	NR	NR	NR
	Left Atrial Diameter, Mean mm (SD)	NR	NR	NR	NR

bpm: beats per minute, cm: centimeter, d: day, CI: confidence interval, HCM: hypertrophic cardiomyopathy, KCCQ-OSS: Kansas City Cardiomyopathy Questionnaire Overall Summary Score, kg: kilogram, LAVI: left atrial volume index, LV: left ventricular, LVEF: left ventricular ejection fraction, LVOT: left ventricular outflow tract, m: meter, mg: milligram, mL: milliliter, mm: millimeter, mm Hg: millimeter of mercury, n: number, N: total number, NA: not applicable, NR: not reported, NRS: numerical rating scale, NT-proBNP: N-terminal pro B-type natriuretic peptide, NYHA: New York Heart Association, pVO<sub>2</sub>: peak oxygen consumption, VE: ventilation, VCO<sub>2</sub>: volume of exhaled carbon dioxide, SD: standard deviation

\*Gene mutation of 40 with genetic testing.

**Table D17. Baseline Characteristics: Disopyramide<sup>29</sup>**

Trial		Sherrid et al. 2005			
Arms		Disopyramide	Disopyramide without Intervention	Disopyramide with Intervention	Non-Disopyramide
N		118	78	40	373
Age at Initial Evaluation, Mean Years (SD)		47 (20)	48 (20)	44 (20)	43 (21)
Duration of Follow-Up, Mean Years (SD)		4.2 (2.9)	NR	NR	6.5 (5.2)
Gender, n (%)	Male	60 (51)	NR	NR	198 (53)
	Female	58 (49)	34 (44)	22 (55)	175 (47)
NYHA Functional Class, Mean (SD)		2.3 (0.7)	2.3 (0.7)	2.3 (0.7)	1.9 (0.8)
NYHA Functional Class Distribution, n (%)	Class I	14 (12)	9 (11.5)	NR	NR
	Class II	59 (50)	40 (51.3)	NR	NR
	Class III or Class IV	45 (38)	29 (37.2)	NR	NR
Disopyramide Dose, Mean mg/day (SD)		432 (181)	425 (169)	445 (201)	NA
Medical History, n (%)	Syncope or Pre-Syncope	55 (47)	NR	NR	97 (26)
	Dyspnea	97 (82)	NR	NR	224 (60)
	NSVT	21 (18)	NR	NR	63 (17)
	Family History of SCD	18 (15)	NR	NR	56 (15)
	AF at Initial Evaluation	24 (20)	NR	NR	67 (18)
	Septal Myectomy	22 (19)	NR	NR	34 (9)
	Septal Ablation	11 (9)	NR	NR	34 (9)
	DDD Pacemaker	13 (11)	NR	NR	52 (14)
	MV Surgery	NR	NR	NR	NR
	All Interventions Combined	40 (34)	NR	NR	104 (28)
	ICD	6 (5)	NR	NR	7 (2)
LVOT Gradient, Mean mm Hg (SD)		74 (35)	75 (33)	73 (35)	62 (32)
MAX LV Wall Thickness, Mean mm (SD)		21.9 (5.5)	21.1 (5)	23.1 (6)	23.7 (6.4)
Coronary Stenosis >70%, n (%)		8 (7)	NR	NR	7 (2)
Background Therapy, n (%)	Beta Blocker	116 (98)	NR	NR	261 (70)
	Calcium Channel Blocker	38 (32)	NR	NR	101 (27)
	Amiodarone	12 (10)	NR	NR	112 (30)

AF: atrial fibrillation, DDD: dual chamber, ICD: implantable cardioverter-defibrillator, mg: milligram, mm Hg: millimeter of mercury, MV: mitral valve, n: number, N: total number, NA: not applicable, NR: not reported, NSVT: non-sustained ventricular tachycardia, NYHA: New York Heart Association, SCD: sudden cardiac death, SD: standard deviation



**Table D18. Baseline Characteristics: Septal Reduction Therapy<sup>30</sup>**

Trial		Liebregts et al. 2015	
Arms		Septal Ablation	Surgical Myectomy
N		2,013	2,791
Age at Initial Evaluation, Weighted Median Years (IQR)		56 (54 to 58)	47 (40 to 47)
Duration of Follow-Up, Mean Years (SD)		6.2	7.4
Gender, Weighted Median % (IQR)	Male	NR	NR
	Female	49.4 (45 to 49.4)	40.1 (37 to 49)
NYHA Functional Class, Weighted Median (IQR)		2.8 (2.8 to 3)	2.9 (2.7 to 3.1)
NYHA Functional Class Distribution, n (%)	Class I	NR	NR
	Class II	NR	NR
	Class III or Class IV	NR	NR
Disopyramide Dose, Mean mg/day (SD)		NA	NA
Medical History, Weighted Median % (IQR)	Syncope or Pre-Syncope	16 (15 to 26)	21 (21 to 29)
	Dyspnea	NR	NR
	NSVT	NR	NR
	Family History of SCD	NR	NR
	AF at Initial Evaluation	NR	NR
	Septal Myectomy	NR	NR
	Septal Ablation	2.5 (2 to 2.6)*	NA
	DDD Pacemaker	NR	NR
	MV Surgery	NA	7.1 (0.0 to 26)
	All Interventions Combined	NR	NR
	ICD	3 (3 to 5)	10 (10 to 10)
LVOT Gradient, Weighted Median mm Hg (IQR)		78 (78 to 104.4)	93 (67.3 to 103)
MAX LV Wall Thickness, Weighted Median mm (IQR)		21 (20.3 to 21)	22.1 (21.9 to 23.5)
Coronary Stenosis >70%, n (%)		NR	NR
Background Therapy, n (%)	Beta Blocker	NR	NR
	Calcium Channel Blocker	NR	NR
	Amiodarone	NR	NR

AF: atrial fibrillation, DDD: dual chamber, ICD: implantable cardioverter-defibrillator, mg: milligram, mm Hg: millimeter of mercury, MV: mitral valve, n: number, N: total number, NA: not applicable, NR: not reported, NSVT: non-sustained ventricular tachycardia, NYHA: New York Heart Association, SCD: sudden cardiac death, SD: standard deviation

\*Alcohol, ml.

Table D19. Efficacy Outcomes: Phase III Trials<sup>24,27</sup>

Trial		EXPLORER-HCM				MAVA-LTE				
Arms		Mavacamten	Placebo	Mavacamten	Placebo	EXPLORER-HCM Cohort				
N		123	128	123	128	224				
Timepoint		14 Weeks		30 Weeks		12 Weeks	24 Weeks	36 Weeks	48 Weeks	60 Weeks
Composite Measure Response n (%)	Either $\geq 1.5$ mL/kg per Min Increase in pVO <sub>2</sub> and NYHA Class Improvement $\geq 1$ OR $\geq 3$ mL/kg per Min Increase in pVO <sub>2</sub> and No Worsening in NYHA Class	NR	NR	45 (37)	22 (17)	NR	NR	NR	NR	NR
	$\geq 1.5$ mL/kg per Min Increase in pVO <sub>2</sub> and NYHA Class Improvement $\geq 1$	NR	NR	41 (33)	18 (14)	NR	NR	NR	NR	NR
	$\geq 3$ mL/kg per Min Increase in pVO <sub>2</sub> and No Worsening in NYHA Class	NR	NR	29 (24)	14 (11)	NR	NR	NR	NR	NR
	Both $\geq 3$ mL/kg per Min Increase in pVO <sub>2</sub> and NYHA Class Improvement $\geq 1$	NR	NR	25 (20)	10 (8)	NR	NR	NR	NR	NR
NYHA Class I & All LVOT Peak Gradients <30 mm Hg, n/N (%)		NR	NR	32/117 (27)	1/126 (1)	NR	NR	NR	NR	NR
Post-Exercise LVOT Peak Gradient <50 mm Hg, n/N (%)		NR	NR	75/101 (74)	22/106 (21)	NR	NR	NR	NR	NR
Post-Exercise LVOT Peak Gradient <30 mm Hg, n/N (%)		NR	NR	64/113 (57)	8/114 (7)	NR	NR	NR	NR	NR
Post-Exercise LVOT Gradient Change from Baseline, Mean (SD)		NR	NR	-47 (40)*	-10 (30) <sup>†</sup>	NR	NR	NR	NR	NR
Resting LVOT Gradient Change from Baseline, Mean mm Hg (SD)		NR	NR	-37.6	-5.2	-30.5 <sup>#</sup>	-33.5 <sup>¥</sup>	-37.9 <sup>++</sup>	-37.7 <sup>##</sup>	-24.1 (30.6) <sup>¥¥</sup>
Valsalva LVOT Gradient Change from Baseline, Mean mm Hg (SD)		NR	NR	-47.6	-11.2	-36.4 <sup>#</sup>	-42.7 <sup>¥</sup>	-51.6 <sup>++</sup>	-47.7 <sup>##</sup>	-42.6 (38.1) <sup>¥¥</sup>

Trial		EXPLORER-HCM				MAVA-LTE				
Arms		Mavacamten	Placebo	Mavacamten	Placebo	EXPLORER-HCM Cohort				
N		123	128	123	128	224				
Timepoint		14 Weeks		30 Weeks		12 Weeks	24 Weeks	36 Weeks	48 Weeks	60 Weeks
Resting LVEF Change from Baseline, % (95% CI)		NR	NR	-3.9	-0.01	-3.9§	-6.2**	-7.1††	-7.9§§	-7.6 (6.9)***
pVO <sub>2</sub> Change from Baseline, Mean mL/kg per Min (SD)		NR	NR	1.4 (3.1)‡	-0.1 (3.0)¶	NR	NR	NR	NR	NR
NYHA Class Improvement ≥1, n (%)		NR	NR	80 (65)	40 (31)	NR	NR	NR	35 (71)##	NR
NYHA Class Mean Change from Baseline (95% CI)		NR	NR	NR	NR	NR	NR	NR	NR	NR
NYHA Functional Class Distribution, n (%)	Class I	39 (31.7)	21 (16.4)	61 (49.6)	27 (21.1)	72 (45.3)§	NR	NR	29 (59.2)##	NR
	Class II	68 (55.3)	82 (64.1)	52 (42.3)	74 (57.8)	74 (46.5)§	NR	NR	16 (32.7)##	NR
	Class III	4 (3.3)	19 (14.8)	8 (6.5)	25 (19.5)	13 (8.2)§	NR	NR	4 (8.2)##	NR
VE/VCO <sub>2</sub> Mean Change from Baseline (95% CI)		NR	NR	-2.6 (-3.6 to -1.5)	NR	NR	NR	NR	NR	NR
NRS Dyspnea Score Mean Change from Baseline (95% CI)		NR	NR	NR	NR	NR	NR	NR	NR	NR
NT-proBNP Level Change from Baseline, Median (IQR), pg/mL (95% CI)		NR	NR	-614.3	30.2	-600#	-605**	-632¶¶	-655##	-356 (-1073 to -148)ʸʸ
Hs-CTnI Change from Baseline, Geometric Mean, ng/L		NR	NR	-5.1	0.1	NR	NR	NR	NR	NR

CI: confidence interval, IQR: interquartile range, kg: kilogram, LVEF: left ventricular ejection fraction, LVOT: left ventricular outflow tract, mL: milliliter, mm Hg: millimeter of mercury, n: number, N: total number, NR: not reported, NRS: numerical rating scale, NT-proBNP: N-terminal pro B-type natriuretic peptide, NYHA: New York Heart Association, pg: picogram, pVO<sub>2</sub>: peak oxygen consumption, VE: ventilation, VCO<sub>2</sub>: volume of exhaled carbon dioxide, SD: standard deviation

\*N=117, †N=122, ‡N=120, ¶N=125, #N=162, §N=159, ¶N=110, \*\*N=108, ††N=97, ‡‡N=93, ¶¶N=94, ##N=49, §§N=47, ʸʸN=23, \*\*\*N=22

**Table D20. Efficacy Outcomes: Phase II Trials<sup>51,59,60</sup>**

Trial		PIONEER-HCM				PIONEER-OLE							
Arms		Cohort A	Cohort B	Cohort A	Cohort B	Cohort A		Cohort B		Mavacamten (Overall)			
N		11*	10	11*	10	5		8		13			
Timepoint		12 Weeks		16 Weeks		12 Weeks	24 Weeks	12 Weeks	24 Weeks	12 Weeks	24 Weeks	36 Weeks	48 Weeks
Composite measure response n (%)	Either $\geq 1.5$ mL/kg per Min Increase in pVO <sub>2</sub> and NYHA Class Improvement $\geq 1$ OR $\geq 3$ mL/kg per Min Increase in pVO <sub>2</sub> and No Worsening in NYHA Class	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
	$\geq 1.5$ mL/kg per Min Increase in pVO <sub>2</sub> and NYHA Class Improvement $\geq 1$	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
	$\geq 3$ mL/kg per Min Increase in pVO <sub>2</sub> and No Worsening in NYHA Class	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
	Both $\geq 3$ mL/kg per Min Increase in pVO <sub>2</sub> and NYHA Class Improvement $\geq 1$	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NYHA Class I & All LVOT Peak Gradients <30 mm Hg, n/N (%)		NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Post-Exercise LVOT Peak Gradient <50 mm Hg, n/N (%)		NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR

Trial		PIONEER-HCM				PIONEER-OLE							
Arms		Cohort A	Cohort B	Cohort A	Cohort B	Cohort A		Cohort B		Mavacamten (Overall)			
N		11*	10	11*	10	5		8		13			
Timepoint		12 Weeks		16 Weeks		12 Weeks	24 Weeks	12 Weeks	24 Weeks	12 Weeks	24 Weeks	36 Weeks	48 Weeks
Post-Exercise LVOT Peak Gradient <30 mm Hg, n/N (%)		8/11 (72.7)	0	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Post-Exercise LVOT Gradient Change from Baseline, Mean (95% CI)		-89.5 (-138.3 to -40.7) <sup>†</sup>	-25 (-47.1 to -3.0) <sup>‡</sup>	-45.1 (-91.2 to 1.0) <sup>†</sup>	-3.5 (-27.5 to 20.5) <sup>‡</sup>	NR	NR	NR	NR	NR	NR	NR	NR
Resting LVOT Gradient Change from Baseline, Mean mm Hg (95% CI)		-47.8 (-72.2 to -23.4)	-48.5 (-82.8 to -14.1)	29.5 (-63.1 to 4.2)	-9.1 (-30.0 to 11.7)	NR	NR	NR	NR	NR	-55.7 (SD: 42.3)	-54.4 (SD: 59.2)	-73.6 (SD: 45.5)
Valsalva LVOT Gradient Change from Baseline, Mean mm Hg (95% CI)		-84.7 (-113.8 to -55.7)	-47.1 (-82.1 to -12.1)	-60.6 (-91.8 to -29.4)	-9.5 (-38.5 to 19.6)	-47.8	-53 <sup>¶</sup>	-77.8	-76.9 <sup>#</sup>	-67.4	-68.3 <sup>§</sup> (SD: 28.9)	-52.1 (SD: 41)	-73.6 (SD: 45.1)
Resting LVEF Change from Baseline, % (95% CI)		-14.6 (-23.1 to -6.2)	-5.5 (-9.8 to -1.2)	-6.2 (-12.2 to -0.2)	-2.8 (-7.5 to 2.0)	-4.4	-4.8 <sup>¶</sup>	-4.5	-3.1 <sup>#</sup>	-4.5	-2.5 (SD: 3.7)	-3.6 (SD: 3.7)	-2.6 (SD: 7.2)
pVO <sub>2</sub> Change from Baseline, Mean mL/kg per Min (95% CI)		3.5 (1.2 to 5.9)	1.7 (0.03 to 3.3)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NYHA Class Improvement ≥1, n (%)		NR	NR	NR	NR	NR	NR	NR	NR	NR	10 (76.9)	NR	NR
NYHA Class Mean Change from Baseline (95% CI)		-0.9 (-1.4 to -0.4)	-1.0 (-1.3 to -0.7)	-0.4 (-1.0 to 0.2)	-0.4 (-0.8 to -0.03)	NR	NR	NR	NR	NR	NR	NR	NR
NYHA Functional Class	Class I	7 (70)	6 (60)	4 (44) <sup>‡</sup>	1 (10)	NR	NR	NR	NR	NR	7 (70) <sup>¥</sup>	NR	3 (50) <sup>#</sup>
	Class II	2 (20)	3 (30)	3 (33) <sup>‡</sup>	7 (70)	NR	NR	NR	NR	NR	3 (30) <sup>¥</sup>	NR	3 (50) <sup>#</sup>

Trial		PIONEER-HCM				PIONEER-OLE							
Arms		Cohort A	Cohort B	Cohort A	Cohort B	Cohort A		Cohort B		Mavacamten (Overall)			
N		11*	10	11*	10	5		8		13			
Timepoint		12 Weeks		16 Weeks		12 Weeks	24 Weeks	12 Weeks	24 Weeks	12 Weeks	24 Weeks	36 Weeks	48 Weeks
Distribution n (%)	Class III	1 (10)	1 (10)	2 (22)‡	2 (20)	NR	NR	NR	NR	NR	0 (0) <sup>¥</sup>	NR	0 (0) <sup>#</sup>
VE/VCO <sub>2</sub> Mean Change from Baseline (95% CI)		-2.2 (-6.1 to 1.7)	-2.5 (-4.3 to -0.7)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NRS Dyspnea Score Mean Change from Baseline (95% CI)		-3.1 (-4.1 to -2.1)	-3.0 (-5.0 to -1.0)	-2.2 (-4.6 to 0.2)	-0.8 (-2.3 to 0.7)	NR	NR	NR	NR	NR	NR	NR	NR
NT-proBNP Level Change from Baseline, Median (IQR), pg/mL (95% CI)		-425 (-748 to -68)	-81 (-637 to -16) <sup>‡</sup>	-629.5 (-804 to 158)	240 (4 to 311)	NR	NR	NR	NR	-1658 (SD: -2695)	-1689 (SD: 2816)	-2243 (SD: 3282)	-3638 (SD: 3947)
Hs-cTnI Change from Baseline, Geometric Mean, ng/L		NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR

CI: confidence interval, IQR: interquartile range, kg: kilogram, LVEF: left ventricular ejection fraction, LVOT: left ventricular outflow tract, mL: milliliter, mm Hg: millimeter of mercury, n: number, N: total number, NR: not reported, NRS: numerical rating scale, NT-proBNP: N-terminal pro B-type natriuretic peptide, NYHA: New York Heart Association, pg: picogram, pVO<sub>2</sub>: peak oxygen consumption, VE: ventilation, VCO<sub>2</sub>: volume of exhaled carbon dioxide, SD: standard deviation

\*N=10 for all reported outcomes unless otherwise stated, †N=8, ‡N=9, ¶N=4, #N=6, §N=12, ¥N=10

Table D21. Efficacy Outcomes: MAVERICK-HCM<sup>15</sup>

Trial		MAVERICK-HCM			
Arms		Group 1 Mava (~200 ng/mL)	Group 2 Mava (~500 ng/mL)	Pooled Mavacamten	Placebo
N		19	21	40	19
Timepoint		16 Weeks			
Composite Measure Response n (%)	Either $\geq 1.5$ mL/kg per Min Increase in $pVO_2$ and NYHA Class Improvement $\geq 1$ OR $\geq 3$ mL/kg per Min Increase in $pVO_2$ and No Worsening in NYHA Class	3 (15.8) (95% CI: 3.4 to 39.6)	6 (28.6) (95% CI: 11.3 to 42.2)	9 (22.5) (95% CI: 10.8 to 38.5)	4 (21.1) (95% CI: 6.1 to 45.6)
	$\geq 1.5$ mL/kg per Min Increase in $pVO_2$ and NYHA Class Improvement $\geq 1$	NR	NR	NR	NR
	$\geq 3$ mL/kg per Min Increase in $pVO_2$ and No Worsening in NYHA Class	NR	NR	NR	NR
	Both $\geq 3$ mL/kg per Min Increase in $pVO_2$ and NYHA Class Improvement $\geq 1$	NR	NR	NR	NR
NYHA Class I & All LVOT Peak Gradients $< 30$ mm Hg, n/N (%)		NR	NR	NR	NR
Post-Exercise LVOT Peak Gradient $< 50$ mm Hg, n/N (%)		NR	NR	NR	NR
Post-Exercise LVOT Peak Gradient $< 30$ mm Hg, n/N (%)		NR	NR	NR	NR
Post-Exercise LVOT Gradient Change from Baseline, Mean (SD)		NR	NR	NR	NR
Resting LVOT Gradient Change from Baseline, Mean mm Hg (SD)		NR	NR	NR	NR
Valsalva LVOT Gradient Change from Baseline, Mean mm Hg (SD)		NR	NR	NR	NR
Resting LVEF Change from Baseline, % (SD)		-2.3 (5.3)	-5.61 (9.65)	-4.09 (8.02)	-2.31 (4.94)
$pVO_2$ Change from Baseline, Mean mL/kg per min (SD)		0.36 (3.12)	0.12 (3.76)	0.22 (3.44)	0.58 (2.39)
NYHA Class Improvement $\geq 1$ , n (%)		10 (52.6); (95% CI: 28.9 to 75.6)	7 (33.3); (95% CI: 14.6 to 57)	17 (42.5); (95% CI: 27 to 59.1)	7 (36.8); (95% CI: 16.3 to 61.6)
NYHA Class Mean Change from Baseline (SD)		-0.6 (0.7)	-0.3 (0.6)	-0.4 (0.7)	-0.4 (0.6)
NYHA Functional Class Distribution, n (%)	Class I	NR	NR	NR	NR
	Class II	NR	NR	NR	NR
	Class III	NR	NR	NR	NR
VE/VCO <sub>2</sub> Mean Change from Baseline (95% CI)		NR	NR	NR	NR
NRS Dyspnea Score Mean Change from Baseline (95% CI)		NR	NR	NR	NR
NT-proBNP Level Change from Baseline, Median (IQR), pg/mL (95% CI)*		-47.1	-57.1	-53.2	-0.7
Hs-CTnI Change from Baseline, Geometric Mean, ng/L*		-23.4	-41	-34	3.8

CI: confidence interval, IQR: interquartile range, kg: kilogram, LVEF: left ventricular ejection fraction, LVOT: left ventricular outflow tract, mL: milliliter, mm Hg: millimeter of mercury, n: number, N: total number, NR: not reported, NRS: numerical rating scale, NT-proBNP: N-terminal pro B-type natriuretic peptide, NYHA: New York Heart Association, pg: picogram,  $pVO_2$ : peak oxygen consumption, VE: ventilation, VCO<sub>2</sub>: volume of exhaled carbon dioxide, SD: standard deviation

\*Percent change.

**Table D22. Efficacy Outcomes: Disopyramide<sup>29</sup>**

Trial		Sherrid et al. 2005	
Arms		Disopyramide without Intervention	Disopyramide with Intervention
N		78	40
Timepoint		3.1 ± 2.6 years	NR
Intervention Type, n (%)	Septal Myectomy	NA	22 (55)
	Septal Ablation	NA	10 (25)
	Dual-Chamber Pacemakers	NA	8 (20)
LVOT Peak Gradient Change from Baseline, Mean mm Hg		-35*	-10*
Re-Intervention, Weighted Median (IQR)		NR	NR
NYHA Class Change from Baseline, Mean (SD)		-0.6*	0
NYHA Class Distribution, n (%)	Class I	29 (37.2)*	NR
	Class II	42 (53.8)*	NR
	Class III/IV	7 (9.0)*	NR

IQR: interquartile range, LVOT: left ventricular outflow tract, n: number, N: total number: NA: not applicable, NR: not reported, NYHA: New York Heart Association, SD: standard deviation

\*Statistically significant.

**Table D23. Efficacy Outcomes: Septal Reduction Therapy<sup>30</sup>**

Trial		Liebregts et al. 2015	
Arms		Septal Ablation	Surgical Myectomy
N		2,013	2,791
Timepoint		Follow-up*	
Intervention Type, n (%)	Septal Myectomy	NR	NR
	Septal Ablation	NR	NR
	Dual-Chamber Pacemakers	NR	NR
LVOT Peak Gradient Change from Baseline, Weighted Median % (IQR)		-71 (-67 to -90)	-77 (-69 to -90)
Re-Intervention, Weighted Median % (95% CI)		7.7 (4.2 to 11.1)	1.6 (0.6 to 2.6)
NYHA Class Change from Baseline, Weighted Median % (IQR)		-45 (-45 to -50)	-45 (-44 to -48)
NYHA Class Distribution, Weighted Median % (95% CI)	Class I	NR	NR
	Class II	NR	NR
	Class III/IV	8 (8 to 8)	4.5 (4.5 to 12)

CI: confidence interval, IQR: interquartile range, LVOT: left ventricular outflow tract, n: number, N: total number: NR: not reported, NYHA: New York Heart Association, SD: standard deviation

\*Timepoints varied between studies in this systematic literature review.



**Table D24. Patient-Reported Outcomes: Phase III Trials<sup>1,24,27</sup>**

Trial		EXPLORER-HCM		MAVA-LTE
Arms		Mavacamten	Placebo	EXPLORER-HCM Cohort
N		123*	128‡	224
Timepoint		30 weeks		NR
KCCQ-CSS Mean Change from Baseline (SD)		13.6 (14.4)	4.2 (13.7)	NR
KCCQ-OSS Mean Change from Baseline (SD)		14.9 (15.8)	5.4 (13.7)	NR
KCCQ-PLS Mean Change from Baseline (SD)		14.7 (17)	3.6 (15.4)	NR
Magnitude of Clinical Change in KCCS-CSS, n (%)	Clinically Worse	9 (10)	22 (25)	NR
	No significant Change	19 (21)	27 (31)	NR
	Small but Clinically Important Improvement	16 (17)	12 (14)	NR
	Moderate to Large Clinical Improvement	15 (16)	16 (18)	NR
	Large to Very Large Improvement	33 (36)	11 (13)	NR
Magnitude of clinical change in KCCS-OSS, n (%)	Clinically Worse	8 (9)	20 (23)	NR
	No Significant Change	18 (20)	28 (32)	NR
	Small but Clinically Important Improvement	17 (18)	9 (10)	NR
	Moderate to Large Clinical Improvement	16 (17)	18 (20)	NR
	Large to Very Large Improvement	33 (36)	13 (15)	NR
HCMSQ-SoB Mean Change from Baseline (SD)		-2.8 (2.7)†	-0.9 (2.4)	NR

HCMSQ-SoB: Hypertrophic Cardiomyopathy Symptom Questionnaire Shortness-of-Breath sub-score, KCCQ-CSS: Kansas City Cardiomyopathy Questionnaire Clinical Summary Score, KCCQ-OSS: Kansas City Cardiomyopathy Questionnaire Overall Summary Score, KCCQ-PLS: Kansas City Cardiomyopathy Questionnaire Physical Limitation Score, n: number, N: total number, NR: not reported, SD: standard deviation

\*N=92 for all reported KCCQ outcomes unless otherwise stated, †N=85, ‡N=88 for all reported KCCQ outcomes unless otherwise stated, ¶N=86

Table D25. Patient-Reported Outcomes: Phase II Trials<sup>51,59</sup>

Trial		PIONEER-HCM				PIONEER-OLE		
Arms		Cohort A	Cohort B	Cohort A	Cohort B	Mavacamten (Overall)		
N		11	10	11	10	13		
Timepoint		12 Weeks		16 Weeks		24 Weeks	36 Weeks	48 Weeks
KCCQ-CSS Mean Change from Baseline (SD)		NR	NR	NR	NR	NR	NR	NR
KCCQ-OSS Mean Change from Baseline (SD)		14.4* (95% CI: 7.3 to 21.5)	16.0 (95% CI: 0.3 to 31.6)	-0.4* (95% CI: -1.0 to 0.2)	-0.4 (95% CI: -0.8 to -0.03)	15.3 (18.5)	NR	16.3 (24.2)
KCCQ-PLS Mean Change from Baseline (SD)		NR	NR	NR	NR	NR	NR	NR
Magnitude of Clinical Change in KCCS-CSS, n (%)	Clinically Worse	NR	NR	NR	NR	NR	NR	NR
	No Significant Change	NR	NR	NR	NR	NR	NR	NR
	Small but Clinically Important Improvement	NR	NR	NR	NR	NR	NR	NR
	Moderate to Large Clinical Improvement	NR	NR	NR	NR	NR	NR	NR
	Large to Very Large Improvement	NR	NR	NR	NR	NR	NR	NR
Magnitude of Clinical Change in KCCS-OSS, n (%)	Clinically Worse	NR	NR	NR	NR	NR	NR	NR
	No Significant Change	NR	NR	NR	NR	NR	NR	NR
	Small but Clinically Important Improvement	NR	NR	NR	NR	NR	NR	NR
	Moderate to Large Clinical Improvement	NR	NR	NR	NR	NR	NR	NR
	Large to Very Large Improvement	NR	NR	NR	NR	NR	NR	NR
HCMSQ-SoB Mean Change from Baseline (SD)		NR	NR	NR	NR	NR	NR	NR

CI: confidence interval, HCMSQ-SoB: Hypertrophic Cardiomyopathy Symptom Questionnaire Shortness-of-Breath sub-score, KCCQ-CSS: Kansas City Cardiomyopathy Questionnaire Clinical Summary Score, KCCQ-OSS: Kansas City Cardiomyopathy Questionnaire Overall Summary Score, KCCQ-PLS: Kansas City Cardiomyopathy Questionnaire Physical Limitation Score, n: number, N: total number, NR: not reported, SD: standard deviation

\*N=10.

**Table D26. Patient-Reported Outcomes: MAVERICK-HCM<sup>15</sup>**

Trial		MAVERICK-HCM			
Arms		Group 1 Mava (~200 ng/mL)	Group 2 Mava (~500 ng/mL)	Pooled Mavacamten	Placebo
N		19	21	40	19
Timepoint		16 weeks			
KCCQ-CSS Mean Change from Baseline (SD)		0.11 (7.67)	5.66 (10.01)	3.37 (9.41)	4.34 (16.05)
KCCQ-OSS Mean Change from Baseline (SD)		0.35 (8.71)	6.24 (10.73)	3.82 (10.24)	6.02 (17.63)
KCCQ-PLS Mean Change from Baseline (SD)		NR	NR	NR	NR
Magnitude of Clinical Change in KCCS-CSS, n (%)	Clinically Worse	NR	NR	NR	NR
	No Significant Change	NR	NR	NR	NR
	Small but Clinically Important Improvement	NR	NR	NR	NR
	Moderate to Large Clinical Improvement	NR	NR	NR	NR
	Large to Very Large Improvement	NR	NR	NR	NR
Magnitude of Clinical Change in KCCS-OSS, n (%)	Clinically Worse	NR	NR	NR	NR
	No Significant Change	NR	NR	NR	NR
	Small but Clinically Important Improvement	NR	NR	NR	NR
	Moderate to Large Clinical Improvement	NR	NR	NR	NR
	Large to Very Large Improvement	NR	NR	NR	NR
HCMSQ-SoB Mean Change from Baseline (SD)		NR	NR	NR	NR

HCMSQ-SoB: Hypertrophic Cardiomyopathy Symptom Questionnaire Shortness-of-Breath sub-score, KCCQ-CSS: Kansas City Cardiomyopathy Questionnaire Clinical Summary Score, KCCQ-OSS: Kansas City Cardiomyopathy Questionnaire Overall Summary Score, KCCQ-PLS: Kansas City Cardiomyopathy Questionnaire Physical Limitation Score, n: number, N: total number, NR: not reported, SD: standard deviation

Table D27. Adverse Events: Phase III Trials<sup>24,27,34</sup>

Trial		EXPLORER-HCM		MAVA-LTE (EXPLORER-HCM Cohort)
Arms		Mavacamten	Placebo	Mavacamten
N		123	128	224
Timepoint		30 weeks		60 weeks
≥ 1 AE, n (%)		NR	NR	NR
≥ 1 TEAE, n (%)		108 (88)	101 (79)	141 (62.9)
≥1 SAE, n (%)		10 (8)	11 (9)	19 (8.5)
AE Severity, n (%)	Mild	NR	NR	82 (36.6)¶
	Moderate	NR	NR	45 (20.1)¶
	Serious/Severe	NR	NR	13 (5.8)¶
Study Drug-Related AEs, n (%)		NR	NR	20 (8.9)¶
Discontinuation, n (%)		4 (3.3)	3 (2.3)	NR
AEs Leading to Treatment Discontinuation, n (%)		2 (1.6)	1 (0.8)	2 (0.9)
Mavacamten Dose Adjustment, n (%)	2.5 mg	NR	NR	NR
	5 mg	NR	NR	NR
	10 mg	NR	NR	NR
	15 mg	NR	NR	NR
Cardiac SAEs, n (%)		4 (3.3)	4 (3.1)	9 (4)#
Atrial Fibrillation, n (%)		8 (6.5)	9 (7)	11 (4.9)
Atrial Flutter, n (%)		NR	NR	NR
Heart Failure, n (%)		NR	NR	2 (0.9)
Systolic Dysfunction, n (%)		NR	NR	NR
Dyspnea, n (%)		NR	NR	10 (4.5)
Syncope, n (%)		2 (2)	1 (1)	NR
Stress Cardiomyopathy, n (%)		2 (2)	0	NR
Palpitations, n (%)		7 (5.7)	9 (7.0)	NR
Coronary Artery Disease, n (%)		NR	NR	NR
Cardiac Failure, n (%)		2 (1.6)	3 (2.3)	NR
Cardiac Failure Congestive, n (%)		0	1 (1)	NR
Ventricular Tachycardia, n (%)		36 (32)*†	38 (33)‡	NR
Angina Pectoris, n (%)		1 (0.8)	5 (3.9)	NR

AE: adverse event, mg: milligram, n: number, N: total number, NR: not reported, SAE: serious adverse event, TEAE: treatment-emergent adverse event

\*Based on week 26 outcomes, †N=113, ‡N=117, ¶Based on teaes, #cardiovascular drug-related events

**Table D28. Adverse Events: Phase II Trials<sup>51,52,59</sup>**

Trial		PIONEER-HCM		PIONEER-OLE
Arms		Cohort A	Cohort B	Mavacamten (Overall)
N		11	10	13
Timepoint		16 weeks		55 weeks
≥ 1 AE, n (%)		NR	NR	11 (84.5)
≥ 1 TEAE, n (%)		NR	NR	NR
≥1 SAE, n (%)		1 (9)	NR	NR
AE Severity, (%)*	Mild	76%	85%	74.5%
	Moderate	23%	15%	14.9%
	Serious/Severe	2%	0%	6.4%
Study Drug-Related AEs, n (%)		21%		NR
Discontinuation, n (%)		2 (18)	0	NR
AEs Leading to Treatment Discontinuation, n (%)		2%	0%	NR
Mavacamten Dose Adjustment, n (%)	2.5 mg	NR	NR	NR
	5 mg	NR	NR	NR
	10 mg	NR	NR	NR
	15 mg	NR	NR	NR
Cardiac SAEs, n (%)		NR	NR	NR
Atrial Fibrillation, n (%)		3 (27)	1 (10)	NR
Atrial Flutter, n (%)		NR	NR	NR
Heart Failure, n (%)		NR	NR	NR
Systolic Dysfunction, n (%)		NR	NR	NR
Dyspnea, n (%)		2 (18)	0	NR
Syncope, n (%)		NR	NR	NR
Stress Cardiomyopathy, n (%)		NR	NR	NR
Palpitations, n (%)		1 (9.1)	0	NR
Coronary Artery Disease, n (%)		NR	NR	NR
Cardiac Failure, n (%)		1 (9.1)	0	NR
Cardiac Failure Congestive, n (%)		NR	NR	NR
Ventricular Tachycardia, n (%)		1 (9.1)	4 (40)	NR
Angina Pectoris, n (%)		0	2 (20)	NR

AE: adverse event, mg: milligram, n: number, N: total number, NR: not reported, SAE: serious adverse event, TEAE: treatment-emergent adverse event

\*Percentages based on numerical instances of each severity of AEs and not number of patients who experienced them.

Table D29. Adverse Events: MAVERICK-HCM<sup>15</sup>

Trial		MAVERICK-HCM			
Arms		Group 1 Mava (~200 ng/mL)	Group 2 Mava (~500 ng/mL)	Pooled Mavacamten	Placebo
N		18	21	39	19
Timepoint		24 weeks			
≥1 AE, n (%)		NR	NR	NR	NR
≥1 TEAE, n (%)		16 (88.9)	19 (90.5)	35 (89.7)	13 (68.4)
≥1 SAE, n (%)		2 (11.1)	2 (9.5)	4 (10.3)	4 (21.1)
AE Severity, n (%)	Mild	76%			
	Moderate	21%			
	Serious/Severe	NR	NR	NR	NR
Study Drug-Related AEs, n (%)		NR	NR	NR	NR
Discontinuation, n (%)		3 (15.8)*	3 (14.3)	6 (15)¶	0
AEs Leading to Treatment Discontinuation, n (%)		NR	NR	NR	NR
Mavacamten Dose Adjustment, n (%)	2.5 mg	1 (5.6)	NA	NR	NA
	5 mg	15 (83.3)	4 (19.0)	NR	NA
	10 mg	2 (11.1)	9 (42.9)	NR	NA
	15 mg	NA	8 (38.0)	NR	NA
Cardiac SAEs, n (%)		NR	NR	NR	NR
Atrial Fibrillation, n (%) <sup>†</sup>		0	3 (14.3)	3 (7.7)	1 (5.3)
Atrial Flutter, n (%) <sup>†</sup>		0	0	0	1 (5.3)
Heart Failure, n (%)		NR	NR	NR	NR
Systolic Dysfunction, n (%) <sup>†</sup>		0	1 (4.8)	1 (2.6)	0
Dyspnea, n (%) <sup>†</sup>		1 (5.6)	3 (14.3)	4 (10.3)	3 (15.8)
Syncope, n (%)		NR	NR	NR	NR
Stress Cardiomyopathy, n (%)		NR	NR	NR	NR
Palpitations, n (%) <sup>‡</sup>		1 (5.6)	5 (23.8)	6 (15.4)	3 (15.8)
Coronary Artery Disease, n (%) <sup>†</sup>		0	0	0	1 (5.3)
Cardiac Failure, n (%)		NR	NR	NR	NR
Cardiac Failure Congestive, n (%)		NR	NR	NR	NR
Ventricular Tachycardia, n (%)		NR	NR	NR	NR
Angina Pectoris, n (%) <sup>†</sup>		0	0	0	1 (5.3)

AE: adverse event, mg: milligram, n: number, N: total number, NR: not reported, SAE: serious adverse event, TEAE: treatment-emergent adverse event

\*N=19, †Based on SAEs, ‡Based on TEAEs, ¶N=40

**Table D30. Adverse Events: Disopyramide<sup>29</sup>**

Trial		Sherrid et al. 2005	
Arms		Disopyramide	Non-Disopyramide
N		118	373
Timepoint		3.1 ± 2.6 years	NR
Discontinuation, n (%)		8 (7)	NR
Pacemaker Implantation, % (95% CI)		NR	NR
Tamponade, % (95% CI)		NR	NR
Sustained Ventricular Tachycardia, % (95% CI)		NR	NR
Ventricular Fibrillation, % (95% CI)		NR	NR
Total Adverse Arrhythmic Events, % (95% CI)		NR	NR
Periprocedural Death, n (%)		NR	NR
Sudden Cardiac Death, n (%)		4 (3.4)	NR
Aborted Sudden Cardiac Death, n (%)		NR	NR
Surgery-Related Death, n (%)		NR	2 (0.5)
Cardiac Mortality, % (95% CI)		NR	NR
Non-Cardiac Mortality, n (%)		NR	NR
All-Cause Mortality, % (95% CI)		NR	NR
Annualized Death Rate, %	Non-Cardiac	1.4	1.2
	Non-Sudden Cardiac	0.4	0.9
	Sudden Cardiac	1	1.8
	All-Cause Cardiac	1.4	2.6
	All Deaths	2.8	3.8
Atrial Fibrillation, n (%)		17 (14)	63 (17)
Stroke, n (%)		4 (3)	7 (2)
ICD Shock, n (%)		NR	NR

CI: confidence interval, ICD: implantable cardioverter-defibrillator, n: number, N: total number, NR: not reported

**Table D31. Adverse Events: Septal Reduction Therapy<sup>30</sup>**

Trial		Liebregts et al. 2015*			
Arms		Septal Ablation	Surgical Myectomy	Septal Ablation	Surgical Myectomy
N		2,013	2,791	2,013	2,791
Timepoint		Short-term (<30 days)*		Long-term (after 30 days)	
Discontinuation, n (%)		NR	NR	NR	NR
Pacemaker Implantation, % (95% CI)		10 (7.8 to 12.1)	4.4 (2.6 to 6.2)	NR	NR
Tamponade, % (95% CI)		0.6 (0.1 to 1.1)	1.0 (0 to 2.0)	NR	NR
Sustained Ventricular Tachycardia, % (95% CI)		0.8 (0.2 to 1.4)	0.4 (0.0 to 1.4)	NR	NR
Ventricular Fibrillation, % (95% CI)		0.8 (0.2 to 1.4)	0.3 (0 to 0.8)	NR	NR
Total Adverse Arrhythmic Events, % (95% CI)		2.2 (1.1 to 3.3)	1.0 (0.1 to 1.8)	NR	NR
Periprocedural Death, n (%)		20 (1)	61 (2.2)	NR	NR
Sudden Cardiac Death, n (%)		NR	NR	36 (1.8)	78 (2.8)
Aborted Sudden Cardiac Death, n (%)		NR	NR	4 (0.2)	15 (0.5)
Surgery-Related Death, n (%)		NR	NR	NR	NR
Cardiac Mortality, n (%)		1.1% (95% CI: 0.6 to 1.6)	2.5% (95% CI: 1.3 to 3.6)	76 (3.8)	175 (6.3)
Non-Cardiac Mortality, n (%)		NR	NR	65 (3.2)	85 (3)
All-Cause Mortality, n (%)		1.3% (95% CI: 0.7 to 1.8)	2.5% (95% CI: 1.4 to 3.6)	191 (9.5)	302 (10.8)
Annualized Death Rate, %	Non-Cardiac	NR	NR	NR	NR
	Non-Sudden Cardiac	NR	NR	NR	NR
	Sudden Cardiac	NR	NR	0.41†	0.49†
	All-Cause Cardiac	NR	NR	0.5	0.74
	All Deaths	NR	NR	1.52 (95% CI: 1.12 to 1.91)	1.44 (95% CI: 1.13 to 1.76)
Atrial Fibrillation, n (%)		NR	NR	NR	NR
Stroke, % (95% CI)		0.3 (0 to 0.8)	0.9 (0.3 to 1.6)	NR	NR
ICD Shock, n (%)		NR	NR	14 (0.7)	11 (0.4)

CI: confidence interval, ICD: implantable cardioverter-defibrillator, n: number, N: total number, NR: not reported

\*All short-term timepoint data (with exception to periprocedural death) presented as % (CI).

†Aborted sudden cardiac death rate.



## D4. Ongoing Studies

**Table D32. Ongoing Studies**

Title / Trial Sponsor	Study Design	Treatment Arms	Patient Population	Primary Outcomes	Estimated Completion Date
<p>A Study to Evaluate Mavacamten in Adults With Symptomatic Obstructive HCM Who Are Eligible for Septal Reduction Therapy (VALOR-HCM)</p> <p>MyoKardia, Inc.</p> <p><a href="#">NCT04349072</a></p>	<p>Phase III, double-blind, multicenter, placebo-controlled, RCT</p> <p>Estimated enrollment: 100</p>	<p><u>Arm 1</u> Mavacamten</p> <p><u>Arm 2</u> Placebo</p>	<p><u>Inclusion Criteria</u></p> <ul style="list-style-type: none"> <li>18 years old and older and body weight &gt;45 kg</li> <li>Diagnosed with HOCM</li> <li>Referred or under active consideration for and willing to have SRT procedure</li> <li>Has documented LVEF ≥60% and oxygen saturation at rest ≥90%</li> </ul> <p><u>Key Exclusion Criteria</u></p> <ul style="list-style-type: none"> <li>Persistent or permanent atrial fibrillation and subject not on anticoagulation for ≥4 weeks prior to screening and/or not adequately rate controlled ≤6 months prior to screening</li> <li>Previously treated with invasive septal reduction (surgical myectomy or septal ablation)</li> <li>For individuals on beta blockers, calcium channel blockers, or disopyramide, any dose adjustment of these medications &lt;14 days prior to screening or an anticipated change in regimen during the first 16 weeks of the study</li> </ul>	<p><u>Primary Outcome</u></p> <ul style="list-style-type: none"> <li>Number of subjects who decide to proceed with SRT and number of subjects who remain eligible for SRT at week 16</li> </ul> <p><u>Secondary Outcomes</u></p> <ul style="list-style-type: none"> <li>Number of subjects who decide to proceed with SRT and number of subjects who remain eligible for SRT at week 32</li> <li>Change from baseline to week 16 in the mavacamten group vs. placebo group in NYHA class</li> <li>Change from baseline to week 16 in the mavacamten group vs. placebo group in KCCQ-23</li> <li>Change from baseline to week 16 in the mavacamten group compared with the placebo group in NT-</li> </ul>	December 2024

Title / Trial Sponsor	Study Design	Treatment Arms	Patient Population	Primary Outcomes	Estimated Completion Date
			<ul style="list-style-type: none"> <li>Any medical condition that precludes upright exercise stress testing</li> <li>Paroxysmal, intermittent atrial fibrillation with atrial fibrillation present at screening</li> <li>Prior treatment with cardiotoxic agents, such as doxorubicin or similar</li> </ul>	proBNP and cardiac troponin <ul style="list-style-type: none"> <li>Change from baseline to week 16 in the mavacamten group vs. placebo group in LVOT gradient</li> </ul>	
A Long-Term Safety Extension Study of Mavacamten in Adults Who Have Completed MAVERICK-HCM or EXPLORER-HCM  MyoKardia, Inc.  <a href="https://clinicaltrials.gov/ct2/show/study/NCT03723655">NCT03723655</a>	Phase II/III, long-term safety extension study	Mavacamten 5 mg/day, with dose adjustments at weeks 4, 8, and 12 if needed	<u>Key Inclusion Criteria</u> <ul style="list-style-type: none"> <li>Has completed MAVERICK-HCM or EXPLORER-HCM</li> <li>Has a body weight &gt;45 kg</li> <li>Has adequate acoustic windows to enable accurate TTEs</li> <li>Has documented LVEF ≥50%</li> </ul> <u>Key Exclusion Criteria</u> <ul style="list-style-type: none"> <li>Has any ECG abnormality that could pose a risk to participant safety</li> <li>Has a history of syncope or a history of sustained ventricular tachyarrhythmia with exercise, resuscitated sudden cardiac arrest or known history of appropriate ICD discharge for life-threatening ventricular arrhythmia</li> <li>Currently treated with disopyramide or ranolazine or treatment with disopyramide or ranolazine is planned during the study</li> </ul>	<ul style="list-style-type: none"> <li>Frequency and severity of TEAEs and SAEs [Timeframe: 252 weeks]</li> </ul>	

Title / Trial Sponsor	Study Design	Treatment Arms	Patient Population	Primary Outcomes	Estimated Completion Date
			<ul style="list-style-type: none"> <li>Has any acute or serious comorbid condition (e.g., major infection or hematologic, renal, metabolic, gastrointestinal, or endocrine dysfunction) that could interfere with the study</li> </ul>		
Extension Study of Mavacamten (MYK-461) in Adults With Symptomatic Obstructive Hypertrophic Cardiomyopathy Previously Enrolled in PIONEER (PIONEER-OLE)  MyoKardia, Inc.  <a href="https://www.clinicaltrials.gov/ct2/show/study/NCT03496168">NCT03496168</a>	Phase II, multicenter, open-label extension study	Mavacamten 5 mg/day, with individualized dose adjustments (5, 10, or 15 mg) at week 6 if needed	<u>Key Inclusion Criteria</u> <ul style="list-style-type: none"> <li>Completed Study MYK-461-004. Prior participation in a non-interventional observational study is allowed</li> <li>Body weight &gt;45 kg at screening</li> </ul> <u>Key Exclusion Criteria</u> <ul style="list-style-type: none"> <li>Has QTcF &gt;500 ms or any other ECG abnormality that could pose a risk to subject safety</li> <li>Has developed obstructive coronary artery disease (&gt;70% stenosis in one or more arteries), known moderate or severe aortic valve stenosis, any acute or serious comorbid condition (e.g., major infection or hematologic, renal, metabolic, gastrointestinal, or endocrine dysfunction) that interfere with the study</li> </ul>	<ul style="list-style-type: none"> <li>Frequency and severity of AEs and SAEs [Timeframe: up to 260 weeks]</li> </ul>	November 9, 2023

AE: adverse event, ECG: electrocardiogram, HCM: hypertrophic cardiomyopathy, HOCM: hypertrophic obstructive cardiomyopathy, ICD: implantable cardioverter-defibrillator, KCCQ: Kansas City Cardiomyopathy Questionnaire, kg: kilogram, LVEF: left ventricular ejection fraction, mg: milligram, ms: millisecond, NT-proBNP: N-terminal pro B-type natriuretic peptide, RCT: randomized controlled trial, SAE: serious adverse event, SRT: septal reduction therapy, TEAE: treatment-emergent adverse event, TTE: transthoracic echocardiogram

Source: [www.ClinicalTrials.gov](https://www.ClinicalTrials.gov) (NOTE: studies listed on site include both clinical trials and observational studies).

## **D5. Previous Systematic Reviews and Technology Assessments**

We did not identify any previous systematic literature reviews on mavacamten in HOCM.

## E. Long-Term Cost Effectiveness: Supplemental Information

### E1. Detailed Methods

Table E1. Impact Inventory

Sector	Type of Impact (Add Additional Domains, As Relevant)	Included in This Analysis from [...] Perspective?		Notes on Sources (if Quantified), Likely Magnitude & Impact (if Not)
		Health Care Sector	Societal	
Formal Health Care Sector				
Health Outcomes	Longevity effects	X		
	Health-related quality of life effects	X		
	Adverse events	X		
Medical Costs	Paid by third-party payers	X		
	Paid by patients out-of-pocket	<input type="checkbox"/>	<input type="checkbox"/>	
	Future related medical costs	<input type="checkbox"/>	<input type="checkbox"/>	
	Future unrelated medical costs	<input type="checkbox"/>	<input type="checkbox"/>	
Informal Health Care Sector				
Health- Related Costs	Patient time costs	N/A	<input type="checkbox"/>	
	Unpaid caregiver-time costs	N/A	<input type="checkbox"/>	
	Transportation costs	N/A	<input type="checkbox"/>	
Non-Health Care Sector				
Productivity	Labor market earnings lost	N/A	X	
	Cost of unpaid lost productivity due to illness	N/A	X	
	Cost of uncompensated household production	N/A	<input type="checkbox"/>	
Consumption	Future consumption unrelated to health	N/A	<input type="checkbox"/>	
Social services	Cost of social services as part of intervention	N/A	<input type="checkbox"/>	
Legal/Criminal Justice	Number of crimes related to intervention	N/A	<input type="checkbox"/>	
	Cost of crimes related to intervention	N/A	<input type="checkbox"/>	
Education	Impact of intervention on educational achievement of population	N/A	<input type="checkbox"/>	
Housing	Cost of home improvements, remediation	N/A	<input type="checkbox"/>	
Environment	Production of toxic waste pollution by intervention	N/A	<input type="checkbox"/>	
Other	Other impacts (if relevant)	N/A	<input type="checkbox"/>	

N/A: not applicable

Adapted from Sanders et al.<sup>61</sup>

## Target Population

The population of focus for the economic evaluation included symptomatic HOCM patients in the US, incorporating demographics at onset of treatment similar to those seen in the EXPLORER trial. The mean age and percent female shown below were used to calculate per cycle mortality rates based on CDC statistics for the US.

**Table E2. Baseline Population Characteristics**

	Mavacamten and Comparators
Mean Age	58
% Female	41%
Source	EXPLORER

## Treatment Strategies

The list of interventions was developed with input from patient organizations, clinicians, manufacturers, and payers on which treatments to include. The full list of interventions is as follows:

- Mavacamten used along with standard first-line treatment.

The comparator(s) for mavacamten along with first-line therapy will be:

- Standard first-line treatment of HOCM (beta blockers and calcium channel blockers)
- Disopyramide used along with standard first-line treatment
- Myectomy used along with standard first-line treatment
- Septal ablation used along with standard first-line treatment.

**Table E3. Treatment Regimen Recommended Dosage**

Generic Name	Mavacamten	Disopyramide	Metoprolol	Verapamil
Brand Name	--	Generic	Generic	Generic
Manufacturer	Bristol Myers Squibb	--	--	--
Route of Administration	Oral	Oral	Oral	Oral
Dosing (Initial and Final Average)	*5-█ mg per day	400-800 mg per day	50-250 mg per day	180-240 mg per day

mg: milligram

\*The dose does not impact costs in the mavacamten arm as a per-year placeholder price is used.

**Table E4. First-Line Drug Use by Arm**

Intervention	Mavacamten	First Line	Disopyramide	Myectomy	Septal Ablation
Metoprolol	76%	74%	98%	75%	75%
Verapamil	20%	13%	32%	8.25%*	8.25%*
Source	EXPLORER	EXPLORER	Sherrid et al.	EXPLORER, literature, and assumption	EXPLORER and assumption

\*16.5% in the initial cycle only, then 8.25% beyond where the 50% reduction after treatment is an assumption consistent with evidence in available small studies on myectomy and assumed to be the same for septal ablation.<sup>9,10</sup>

## Model Inputs

### Clinical Inputs

Key clinical inputs included transitions between NYHA class and mortality. The best-available evidence was reviewed for inclusion in the model. The base-case treatment effects influenced NYHA class transitions and, for mavacamten and standard first-line care and standard first-line care alone, came from a Phase III clinical trial of mavacamten. Treatment effects of disopyramide along with first-line treatment, myectomy with first-line treatment and septal ablation with standard first line treatment, came from key literature sources.<sup>1,2</sup>

### *Transition Probabilities and Treatment Effects*

Transitions between NYHA class for mavacamten with first-line therapy and for first-line therapy alone were derived from those seen in EXPLORER clinical trial data up to Cycle 8. For mavacamten and standard first-line therapy and first-line therapy alone, clinical trial data were used directly in Cycles 0 and 1 (weeks 0 and four). For weeks four through 12 in the model, the transition rates were fitted cycle by cycle to match clinical trial data available at week 14 using an assumption of a constant weekly exponential rate. For weeks 12 through 24 in the model, the transitions were based on information available from weeks 14 through 26 in the clinical trial data. For weeks 28 and 32, the transition rates were based on transitions observed between weeks 26 and 30 in EXPLORER trial data. Following Cycle 8, the proportions of live patients across NYHA class were held constant.

For disopyramide along with standard first-line therapy, baseline, and week four distributions across NYHA class were based on data in Sherrid et al. where the distribution across NYHA class in week four in the model is as seen in disopyramide patients who remained on treatment for several years in 66% of the patients and assumed to be 0 in 34% of the patients as 34% of the patients in the Sherrid study had eventually opted for surgical options. Following Cycle 1 (week four) in the disopyramide along with standard first-line therapy arm, we held the proportions of alive patients across NYHA classes constant. The disopyramide and standard first-line therapy patients also had

their mortality modeled based on US CDC mortality rates corresponding to the average age and percent female characteristics seen in the EXPLORER trial patients.

Myectomy patients and septal ablation were modeled having the same baseline distribution of NYHA class as the mavacamten patients in EXPLORER. For the treatment effect of myectomy along with first-line therapy and septal ablation with standard first-line therapy in the model, the percent of patients in week four in NYHA class I is such that it makes the percent reduction in the average NYHA class between Cycles 0 and 1 (weeks 0 and four) equal to the percent reduction seen in the Liebrechts meta-analysis (55% reduction), keeping the relative percent of those remaining in NYHA class II and NYHA class III/IV in the same proportion as that seen in the mavacamten population in week four. Simultaneously, between weeks 0 and four, 1.3% of the myectomy patients and 1.1% of the septal ablation patients were modeled as dying from the procedure based on rates from studies in years later than 2000 as shown in Liebrechts. Following week four, the relative portion of alive patients across NYHA class was held constant, and mortality is based on average demographic characteristics seen in EXPLORER.

Specific treatment effects are shown via NYHA class below in Table E6 for disopyramide and standard first-line therapy and myectomy and standard first-line therapy. Septal ablation and standard first-line therapy had the same treatment effect in Cycle 1 consistent with results in Liebrechts.

**Table E5. Specific Treatment Effects**

Clinical Inputs			
Input Name	Base Case (Percent in NYHA I in Cycle 1)	Lower Value	Upper Value
<b>Mavacamten Treatment Effect*</b>	0.24	0.18	0.31
<b>Standard First-Line Therapy Treatment Effect</b>	0.08	0.06	0.10
<b>Myectomy Treatment Effect*</b>	0.77	0.58	0.96
<b>Disopyramide Treatment Effect*</b>	0.28	0.21	0.36
<b>Septal Ablation Treatment Effect*</b>	0.77	0.58	0.96

NYHA: New York Heart Association

\*With standard first-line therapy.

### ***Discontinuation***

Discontinuation was not included in the model as there was no long-term evidence suggesting an appropriate estimate for mavacamten, and as first-line therapy tends to be used for life in this patient population. We did make an adjustment in the treatment effect for disopyramide described above that is related to discontinuation in those patients, however, in the model, technically, no one discontinues.



## ***Mortality***

Mortality estimates were sourced from the CDC and reflected US average mortality rates adjusted for age and gender as reflected by the overall averages of baseline characteristics of patients seen in the clinical trial. Based on conversations with clinical experts and available evidence, mortality was assumed to be constant across NYHA class as there is not enough evidence from the trial to warrant projecting mortality effects for mavacamten along with first-line therapy relative to other treatments, although this assumption was tested in a scenario analysis. Note that for myectomy and septal ablation, as stated above, there is an initial increase in mortality based on mortality rates associated with the procedure.<sup>2</sup>

## ***Adverse Events***

In EXPLORER, 8% of patients experienced a serious adverse event in the mavacamten arm and 9% in the standard-of-care/placebo arm.<sup>3</sup> As the rate of serious adverse events across the arms was very similar and because we have limited data to compare serious adverse events with the other comparators, we did not include additional costs or disutilities of serious adverse events in the model. However, utility impacts of the serious adverse events would have been captured in the utility scores used across NYHA class for mavacamten and standard of care (see Health State Utilities section below). For the disopyramide, myectomy, and septal ablation arms, we do not include impacts of adverse events in the model (although there is a surgical disutility for myectomy and septal ablation and there are total cost estimates used from the literature that would include costs of adverse events for those procedures) and we use an average of the utility scores for each NYHA class seen in EXPLORER to project the treatment effect of changes in NYHA class to changes in QALYs.

## ***Heterogeneity and Subgroups***

There is insufficient evidence to warrant or allow modeling of subgroups within the treatments or comparators.

## **Health State Utilities**

Health state utilities were based on manufacturer-submitted data for NYHA class I, II, and III/IV. We used consistent health state utility values across treatments evaluated in the model. The utilities were taken directly from the patients in the trial and, as such, they include disutilities from the small difference in adverse events seen in the trial. Consequently, we did not add additional disutilities for serious adverse events in the model. No head-to-head data are available to compare adverse event rates in mavacamten and first-line therapy versus disopyramide and first-line therapy and/or myectomy or septal ablation with first-line therapy. It was reported that 7% of patients on disopyramide experienced adverse side effects leading to discontinuation, which is similar to the

adverse event rates of 8% and 9% seen in EXPLORER. Given available data, we elected to use an average of the utilities for placebo and mavacamten for the utilities by NYHA class for the other comparators. The utility scores are based on the EQ-5D administered to the patients in EXPLORER.<sup>4</sup> In addition, we applied an average disutility by age of 0.0007 per year, which reflects average age decrements seen in the EQ-5D in the US.<sup>5</sup> For myectomy, a disutility of 0.086 is applied for the first six cycles matching available numbers for coronary artery bypass surgery patients versus US average utilities for similarly aged patients using the EQ-5D.<sup>6</sup> For septal ablation, a one cycle disutility of 0.04 is applied.<sup>6,2</sup> Further, for myectomy and septal ablation there is a 0.05 lifetime disutility applied to 4% and 10% of patients respectively reflecting different rates of pacemaker placement related to those procedures as seen in the literature.<sup>30</sup>

**Table E6. Health State Utilities**

Input Came	Treatment	Base Case	Lower Value	Upper Value
Utility of NYHA Class I for Mavacamten	Mavacamten	0.95	0.65	1.00
Utility of NYHA Class II for Mavacamten	Mavacamten	0.87	0.66	0.98
Utility of NYHA Class III and IV for Mavacamten	Mavacamten	0.71	0.56	0.84
Utility of NYHA Class I for SoC	Standard	0.95	0.65	1.00
Utility of NYHA Class II for SoC	Standard	0.85	0.65	0.97
Utility of NYHA Class III and IV for SoC	Standard	0.70	0.56	0.83
Utility of NYHA Class I for Comparators	Myectomy, septal ablation, disopyramide	0.95	0.65	1.00
Utility of NYHA Class II for Comparators	Myectomy, septal ablation, disopyramide	0.86	0.65	0.98
Utility of NYHA Class III and IV for Comparators	Myectomy, septal ablation, disopyramide	0.71	0.56	0.83
Disutility of Pacemaker	Myectomy and septal ablation	0.05	0.04	0.05
Disutility of Septal Ablation Procedure	Septal ablation (1 cycle)	0.04	0.03	0.05
Disutility of Myectomy Procedure	Myectomy (6 cycles)	0.09	0.07	0.10

NYHA: New York Heart Association, SoC: standard of care

### **Drug Utilization**

Patients in all the arms were modeled as using beta blockers represented by metoprolol and calcium channel blockers represented by verapamil according to usual doses for extended-release versions of those drugs associated with adult hypertension.<sup>7,8</sup> For myectomy and septal ablation patients, post-myectomy use of verapamil will be reduced by 50% based on available pre-post studies of myectomy.<sup>9,10</sup> See Table E7 for the doses used and Table E8 for the proportions using first-line treatment in the model.

The following inputs were used to model drug utilization and associated costs:

- Duration of treatment
- Schedule of doses for each drug in each regimen
- Protocol/label dosage for the indication.

## Cost Inputs

### Drug Costs

For mavacamten, we used a placeholder price based on market analyst estimates.<sup>11</sup> For disopyramide, metoprolol, and verapamil, we calculated the average wholesale acquisition cost (WAC) based on generic formulations in Red Book (see Table E9). Other than an initial hospitalization associated with disopyramide (see Table E10), no administration costs were included because all drugs included in the model are orally administered.

**Table E7. Drug Costs**

Input Name	Treatment	Base Case	Lower Value	Upper Value
Per Cycle Cost of Mavacamten	Mavacamten	\$5,769	\$4,694	\$6,954
First Cycle Cost of Metoprolol	Metoprolol cycle 1	\$38	\$31	\$46
Per Cycle Cost of Metoprolol	Metoprolol	\$64	\$52	\$77
First Cycle Cost of Verapamil	Verapamil cycle 1	\$49	\$40	\$59
Per Cycle Cost of Verapamil	Verapamil	\$56	\$46	\$67
First Cycle Cost of Disopyramide	Disopyramide cycle 1	\$309	\$252	\$373
Per Cycle Cost of Disopyramide	Disopyramide	\$413	\$336	\$497

\*All costs used in the model were updated to 2021 dollars based on the methods outlined in the [ICER Reference Case](#).

### Non-Drug Costs

Non-drug costs were modeled based on NYHA class derived from data provided by Bristol Myers Squibb for NYHA class I and II, which reflect non-symptomatic HOCM and symptomatic HOCM patients, respectively, and were projected from the NYHA class II to NYHA class III proportionally based on proportional differences across those classes seen in general heart failure patients in a recent model.<sup>12</sup>

In addition, there were echocardiograph costs at week 0, week eight, and week 16 applied to the mavacamten and first-line treatment arm, in addition to having those done initially and every two years for all of the comparators (see Table E10). There are also two days of hospital costs applied to disopyramide upon treatment initiation, and the cost used for myectomy and septal ablation reflects total costs associated inclusive of the surgery costs as well as inpatient, surgical, outpatient and emergency room use in six months following those surgeries in a recent claims data analysis.<sup>63</sup>

**Table E8. Non-Drug Costs**

Cost Inputs*				
Input Name	Treatment	Base Case	Lower Value	Upper Value
Disopyramide Hospitalization	Disopyramide hospitalization	\$8,559	\$6,964	\$10,316
Myectomy Procedure Cost	Myectomy	\$122,759	\$99,881	\$147,960
Septal Ablation Procedure Cost	Septal ablation	\$55,706	\$45,325	\$67,142
Echocardiogram Cost	Transthoracic TTE (93308)	\$101	\$82	\$121
NYHA I Heath State Cost	NYHA I heath state cost			
NYHA II Heath State Cost	NYHA II heath state cost			
NYHA III Heath State Cost	NYHA III heath state cost	\$2,826	\$2,299	\$3,406

NYHA: New York Heart Association, TTE: transthoracic echocardiogram

\*All costs used in the model were updated to 2021 dollars based on the methods outlined in the [ICER Reference Case](#).

## E2. Results

### Description evLYG Calculations

The cost per evLYG considers any extension of life at the same “weight” no matter what treatment is being evaluated. Below are the stepwise calculations used to derive the evLYG in cases where the life expectancy was different across treatment arms.

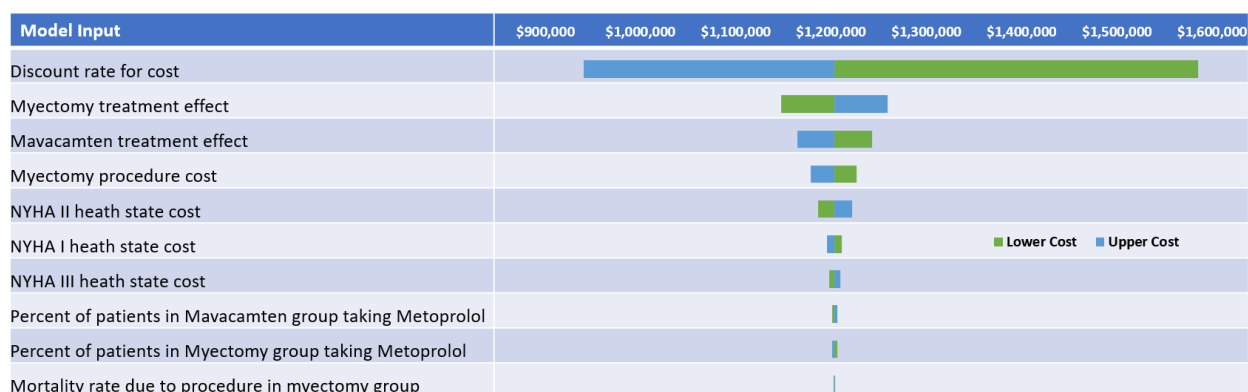
1. First, we attribute a utility of 0.851, the age- and gender-adjusted utility of the general population in the US that are considered healthy.<sup>64</sup>
2. For each cycle (Cycle I) in the model where using the intervention results in additional years of life gained, we multiply this general population utility with the additional life years gained ( $\Delta$ LYG).
3. We sum the product of the life years and average utility (cumulative LYs/cumulative QALYs) for Cycle I in the comparator arm with the value derived in Step 2 to derive the equal value of life years (evLY) for that cycle.
4. If no life years were gained using the intervention versus the comparator, evLYs are equivalent to QALYs
5. The total evLY is then calculated as the cumulative sum of QALYs gained using the above calculations for each arm.
6. We use the same calculations in the comparator arm to derive its evLY.

Finally, the evLYG is the incremental difference in evLY between the intervention and the comparator arms.

## E3. Sensitivity Analyses

To demonstrate effects of uncertainty on both costs and health outcomes, we varied input parameters using available measures of parameter uncertainty (i.e., standard errors) or reasonable ranges to evaluate changes in cost per addition QALY. Figures E1A and E1B and Tables 9A and 9B show the tornado diagrams for mavacamten versus myectomy in terms of costs and then in terms of QALYs. As this is a lifetime model, the incremental costs are sensitive to the discount rate. Varying the treatment effects (increasing the proportion in NYHA I) also has a moderate impact. The treatment effects and NYHA utility scores have a relatively large effect on projected incremental QALYs. Overall, however, the sensitivity analyses demonstrated robust findings that at a price of \$75,000 per year, the incremental ratios would be above standard thresholds. These analyses were repeated for the other comparators with similar findings displayed below.

**Figure E1A. Tornado Diagram of Incremental Cost for Mavacamten versus Myectomy**



NYHA: New York Heart Association

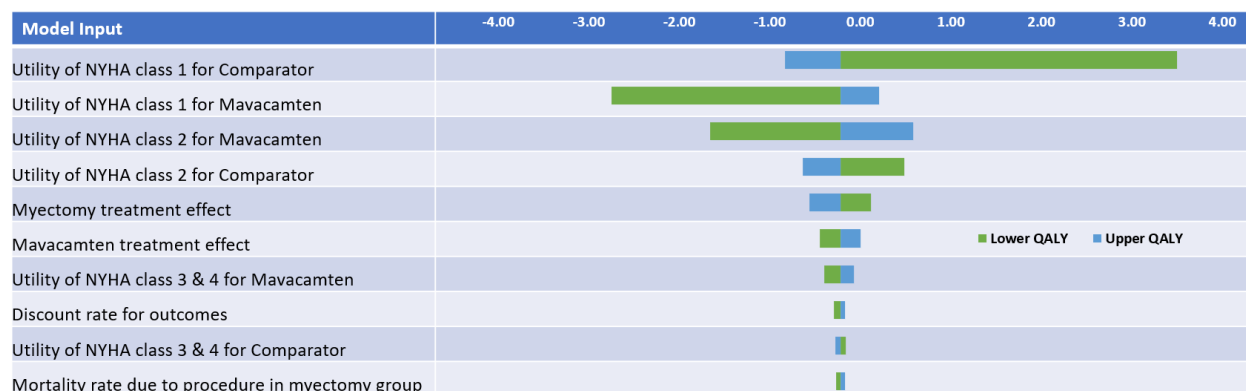
**Table E9A. Inputs and Results for Mavacamten versus Myectomy Incremental Cost Tornado Diagram**

Input	Lower Cost	Upper Cost	Low Input Value	High Input Value
Discount Rate for Cost	\$1,584,965	\$940,538	0.01	0.05
Myectomy Treatment Effect	\$1,147,719	\$1,259,440	0.58	0.96
Mavacamten Treatment Effect	\$1,242,588	\$1,164,572	0.18	0.31
Myectomy Procedure Cost	\$1,226,457	\$1,178,379	\$99,881.32	\$147,959.69
NYHA II Heath State Cost	\$1,186,641	\$1,222,239	\$1,663.84	\$2,464.74
NYHA I Heath State Cost	\$1,210,829	\$1,195,594	\$611.31	\$905.57
NYHA III Heath State Cost	\$1,198,253	\$1,209,448	\$2,299.24	\$3,405.99
Percent of Patients in Mavacamten Group Taking Metoprolol	\$1,200,969	\$1,206,190	0.57	0.95
Percent of Patients in Myectomy Group Taking Metoprolol	\$1,206,122	\$1,201,037	0.56	0.94
Mortality Rate Due to Procedure in Myectomy Group	\$1,202,793	\$1,204,366	0.01	0.02

NYHA: New York Heart Association, SoC: standard of Care

\*Note lower input may reflect either upper or lower ICER value depending on the direction that the input has on the ICER output.

**Figure E1B. Tornado Diagram of Incremental QALY for Mavacamten versus Myectomy**



NYHA: New York Heart Association

**Table E9B. Inputs and Results for Mavacamten versus Myectomy Incremental QALY Tornado Diagram**

Input	Lower QALY	Upper QALY	Low Input Value	High Input Value
Utility of NYHA Class I for Comparator	3.50	-0.83	0.65	1.00
Utility of NYHA Class I for Mavacamten	-2.75	0.20	0.65	1.00
Utility of NYHA Class II for Mavacamten	-1.66	0.58	0.66	0.98
Utility of NYHA Class II for Comparator	0.48	-0.63	0.65	0.98
Myectomy Treatment Effect	0.12	-0.56	0.58	0.96
Mavacamten Treatment Effect	-0.45	0.01	0.18	0.31
Utility of NYHA Class III and IV for Mavacamten	-0.40	-0.07	0.56	0.84
Discount Rate for Outcomes	-0.29	-0.17	0.01	0.05
Utility of NYHA Class III and IV for Comparator	-0.16	-0.27	0.56	0.83
Mortality Rate Due to Procedure in Myectomy Group	-0.27	-0.17	0.01	0.02

NYHA: New York Heart Association, QALY: quality-adjusted life year

Figure E2 shows the tornado diagram for mavacamten versus septal ablation. Similar findings as described above.

**Figure E2A. Tornado Diagram of Incremental Cost for Mavacamten versus Septal Ablation**



ASA: alcohol septal ablation, NYHA: New York Heart Association

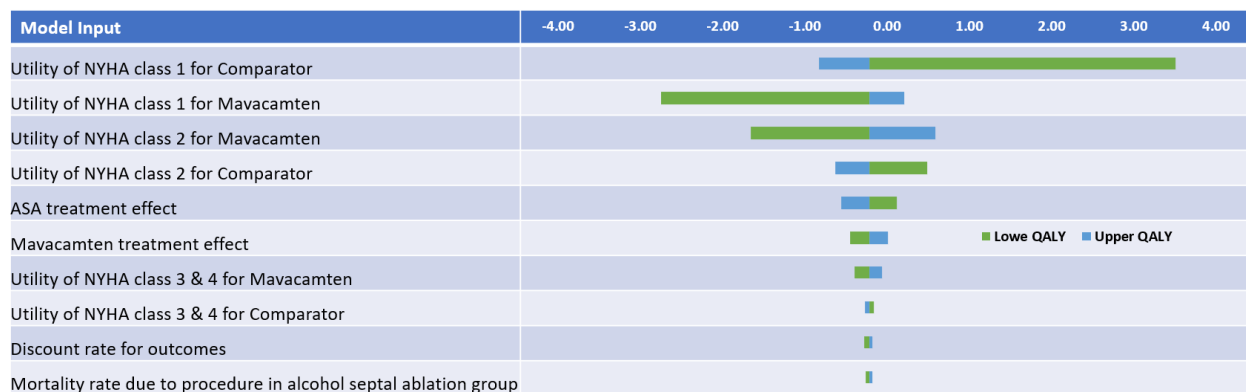
**Table E10A. Inputs and Results for Mavacamten versus Septal Ablation Incremental Cost Tornado Diagram**

Input	Low Cost	Upper Cost	Low Input Value	High Input Value
Discount Rate for Cost	\$1,651,393	\$1,007,202	0.01	0.05
ASA Treatment Effect	\$1,214,174	\$1,326,121	0.58	0.96
Mavacamten Treatment Effect	\$1,309,156	\$1,231,140	0.18	0.31
NYHA II Heath State Cost	\$1,253,243	\$1,288,770	\$1,663.84	\$2,464.74
ASA Procedure Cost	\$1,280,529	\$1,258,712	\$45,324.87	\$67,142.21
NYHA I Heath State Cost	\$1,277,443	\$1,262,112	\$611.31	\$905.57
NYHA III Heath State Cost	\$1,264,826	\$1,276,010	\$2,299.24	\$3,405.99
Percent of Patients in Mavacamten Group Taking Metoprolol	\$1,267,538	\$1,272,758	0.57	0.95
Percent of Patients in ASA Group Taking Metoprolol	\$1,272,696	\$1,267,600	0.56	0.94
Mortality Rate Due to Procedure in ASA Group	\$1,269,482	\$1,270,814	0.01	0.01

ASA: alcohol septal ablation, NYHA: New York Heart Association, SoC: standard of Care

\*Note lower input may reflect either upper or lower ICER value depending on the direction that the input has on the ICER output.

**Figure E2B. Tornado Diagram of Incremental QALY for Mavacamten versus Septal Ablation**



ASA: alcohol septal ablation, NYHA: New York Heart Association



**Table E10B. Inputs and Results for Mavacamten versus Septal Ablation Incremental QALY Tornado Diagram**

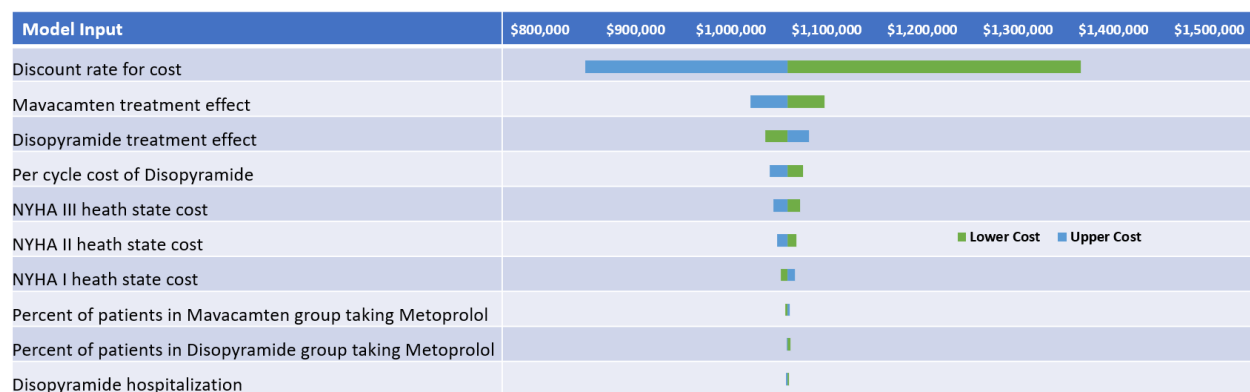
Input	Low QALY	Upper QALY	Low Input Value	High Input Value
Utility of NYHA Class I for Comparator	3.50	-0.83	0.65	1.00
Utility of NYHA Class I for Mavacamten	-2.75	0.21	0.65	1.00
Utility of NYHA Class II for Mavacamten	-1.66	0.59	0.66	0.98
Utility of NYHA Class II for Comparator	0.49	-0.63	0.65	0.98
ASA Treatment Effect	0.12	-0.56	0.58	0.96
Mavacamten Treatment Effect	-0.45	0.01	0.18	0.31
Utility of NYHA class III and IV for Mavacamten	-0.39	-0.06	0.56	0.84
Utility of NYHA class III and IV for Comparator	-0.16	-0.27	0.56	0.83
Discount Rate for Outcomes	-0.28	-0.17	0.01	0.05
Mortality Rate Due to Procedure in ASA Group	-0.26	-0.18	0.01	0.01

ASA: alcohol septal ablation, NYHA: New York Heart Association, SoC: standard of Care

\*Note lower input may reflect either upper or lower ICER value depending on the direction that the input has on the ICER output.

Figures E3A and E3B and Table E11 describe the one-way sensitivity analyses for mavacamten versus disopyramide.

**Figure E3A. Tornado Diagram of Incremental Cost for Mavacamten versus Disopyramide**



NYHA: New York Heart Association

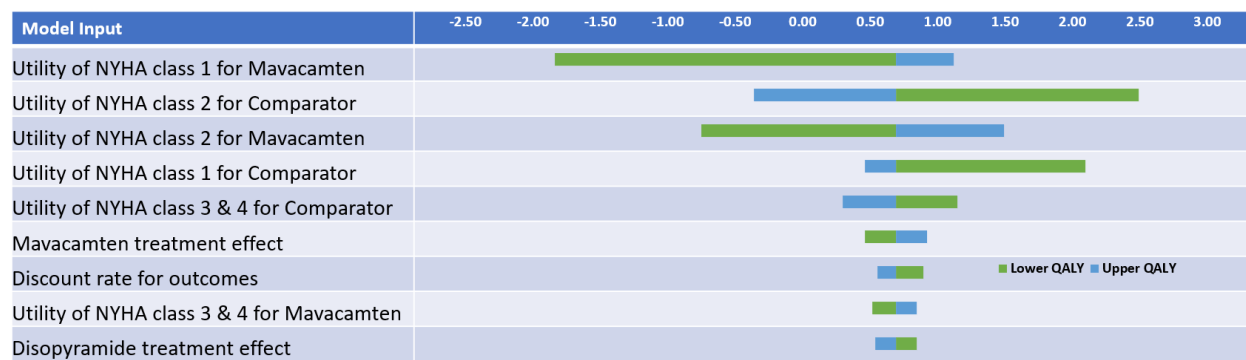
**Table E11A. Inputs and Results for Mavacamten versus Disopyramide Incremental Cost Tornado Diagram**

Input	Lower Cost	Upper Cost	Low Input Value	High Input Value
Discount Rate for Cost	\$1,365,337	\$847,335	0.01	0.05
Mavacamten Treatment Effect	\$1,097,781	\$1,019,765	0.18	0.31
Disopyramide Treatment Effect	\$1,035,926	\$1,081,621	0.21	0.36
Per Cycle Cost of Disopyramide	\$1,075,272	\$1,040,599	\$335.65	\$497.22
NYHA III Heath State Cost	\$1,071,779	\$1,044,447	\$2,299.24	\$3,405.99
NYHA II Heath State Cost	\$1,068,255	\$1,048,329	\$1,663.84	\$2,464.74
NYHA I Heath State Cost	\$1,051,832	\$1,066,420	\$611.31	\$905.57
Percent of Patients in Mavacamten Group Taking Metoprolol	\$1,056,163	\$1,061,384	0.57	0.95
Percent of Patients in Disopyramide Group Taking Metoprolol	\$1,062,139	\$1,058,499	0.74	1.00
Disopyramide Hospitalization	\$1,060,368	\$1,057,016	\$6,963.60	\$10,315.56

NYHA: New York Heart Association, SoC: standard of care

\*Note lower input may reflect either upper or lower ICER value depending on the direction that the input has on the ICER output.

**Figure E3A. Tornado Diagram of Incremental QALY for Mavacamten versus Disopyramide**



NYHA: New York Heart Association

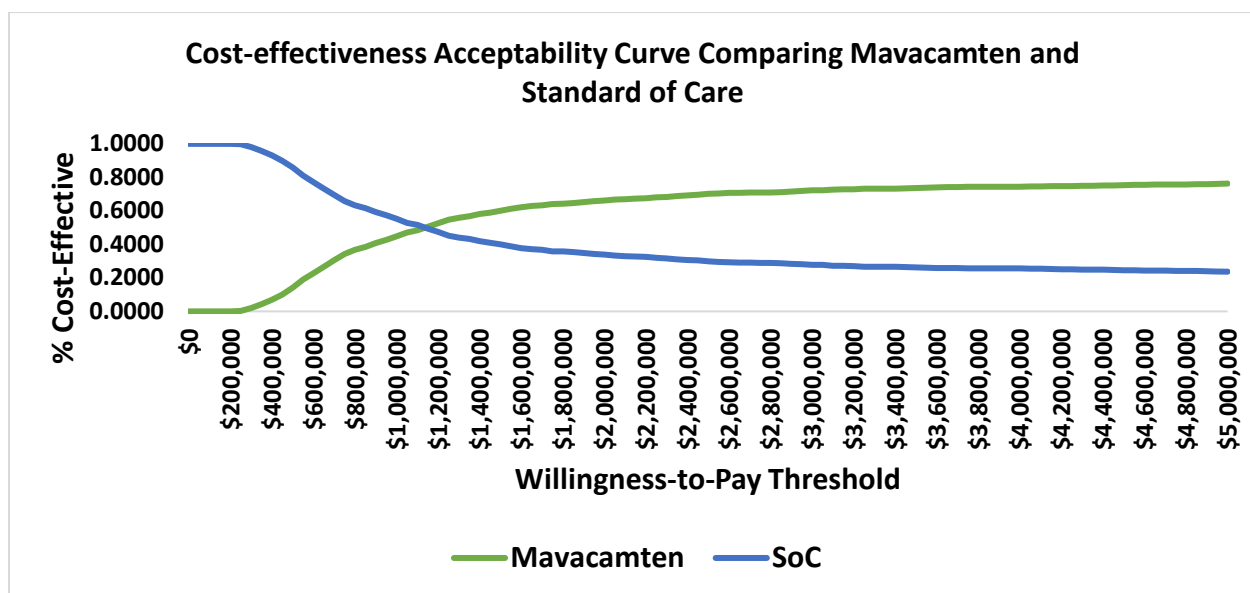
**Table E11B. Inputs and Results for Mavacamten versus Disopyramide Incremental QALY Tornado Diagram**

Input	Lower QALY	Upper QALY	Low Input Value	High Input Value
Utility of NYHA Class I for Mavacamten	-1.84	1.12	0.65	1.00
Utility of NYHA Class II for Comparator	2.49	-0.36	0.65	0.98
Utility of NYHA Class II for Mavacamten	-0.75	1.50	0.66	0.98
Utility of NYHA Class I for Comparator	2.10	0.46	0.65	1.00
Utility of NYHA Class III and IV for Comparator	1.15	0.30	0.56	0.83
Mavacamten Treatment Effect	0.46	0.92	0.18	0.31
Discount Rate for Outcomes	0.89	0.55	0.01	0.05
Utility of NYHA Class III and IV for Mavacamten	0.52	0.84	0.56	0.84
Disopyramide Treatment Effect	0.85	0.54	0.21	0.36

NYHA: New York Heart Association, QALY: quality-adjusted life year

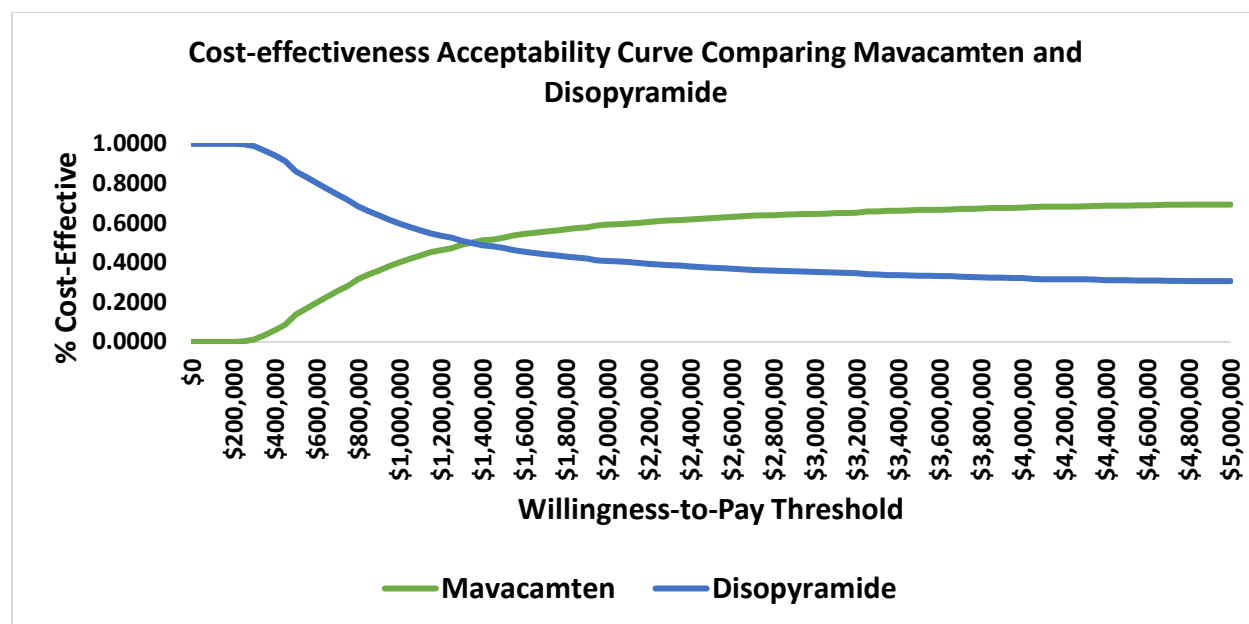
Figures E4-E7 show results of the probabilistic sensitivity analyses for mavacamten plus standard first-line therapy versus all the comparators. At willingness-to-pay threshold levels under \$200,000 per QALY essentially none of the simulations project mavacamten to be cost effective. Even at extremely high willingness-to-pay thresholds the proportion of simulations was not much above half for mavacamten plus first-line therapy being cost effective. All of these incorporated the placeholder price of mavacamten as its average cost.

**Figure E4. Probabilistic Sensitivity Analysis Results: Cost-Effectiveness Acceptability Curves for Mavacamten and Standard of Care**

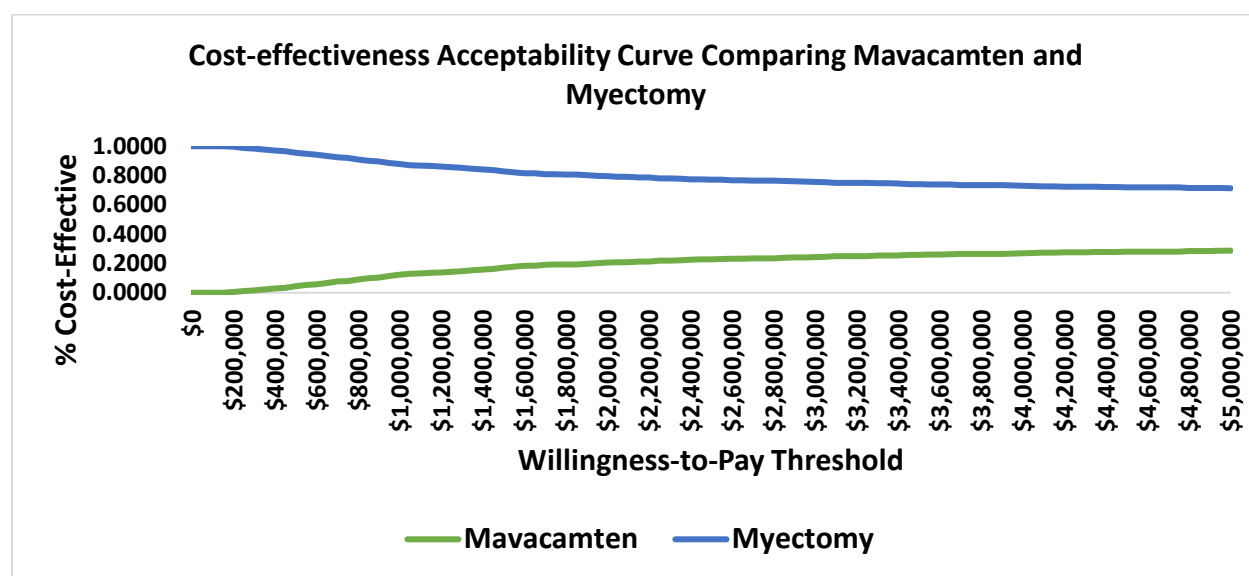


SoC: standard of care

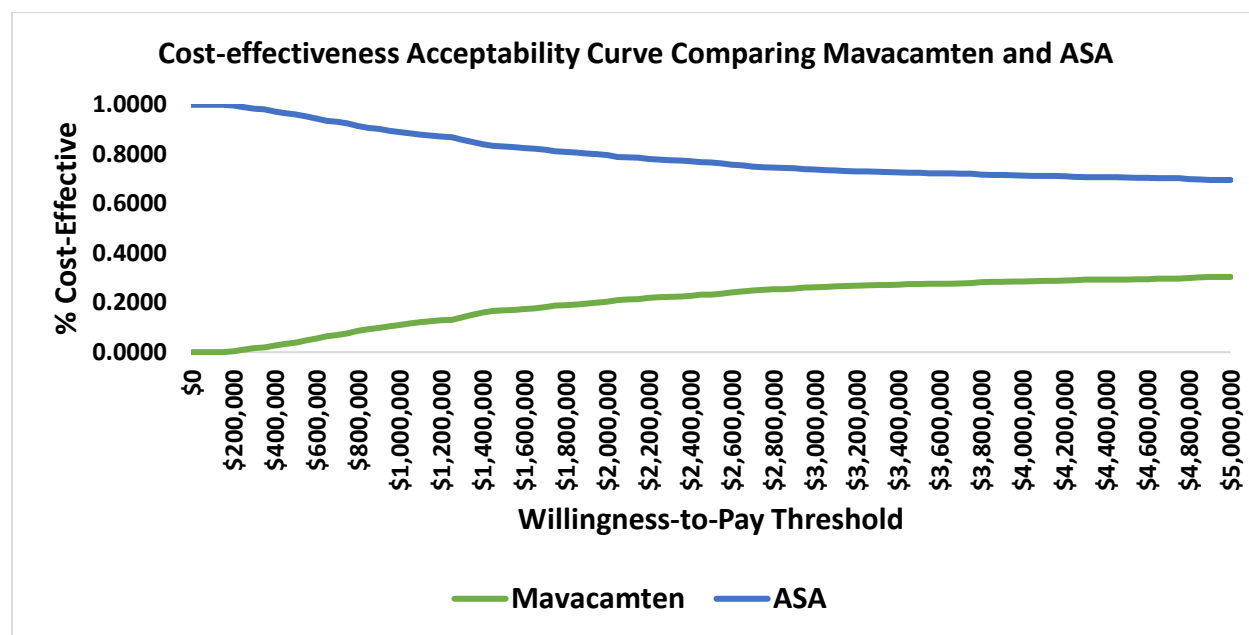
**Figure E5. Probabilistic Sensitivity Analysis Results: Cost-Effectiveness Acceptability Curves for Mavacamten and Disopyramide**



**Figure E6. Probabilistic Sensitivity Analysis Results: Cost-Effectiveness Acceptability Curves for Mavacamten and Myectomy**



**Figure E7. Probabilistic Sensitivity Analysis Results: Cost-Effectiveness Acceptability Curves for Mavacamten and Septal Ablation**



ASA: alcohol septal ablation

## E4. Scenario Analyses

We included a scenario using a higher mortality rate for patients in NYHA class III/IV. We also included a scenario where NYHA class I was associated with full employment and the other classes with no employment in comparing mavacamten and first-line therapy with first-line therapy alone. In addition, we included a scenario where mavacamten and first-line therapy was associated with full employment and first-line therapy alone was associated with having no employment. In all of them, the incremental cost-effectiveness ratio was higher than standard threshold values.

## E5. Model Validation

### Prior Economic Models

There were no prior published cost-effectiveness models for HOCM patients. Some of the model inputs were informed by heart failure models available in the literature. In particular, Zueger et al. 2018 used a heart failure model based on NYHA class to project the cost effectiveness of various treatments for heart failure. Our model incorporated the percent difference in non-treatment costs between patients in NYHA II and NYHA III/IV seen in that model in projecting non-treatment related costs for HOCM patients. Our model was also informed by discussions and data provided academic in confidence by modelers employed by Bristol Myers Squibb. However, that model has yet to be published.

## F. Potential Budget Impact: Supplemental Information

### **Methods**

We used results from the same model employed for the cost-effectiveness analyses to estimate total potential budget impact. Potential budget impact was defined as the total differential cost of using mavacamten rather than standard therapy for the treated population, calculated as differential health care costs (including drug costs) minus any offsets in these costs from averted health care events. All costs were undiscounted and estimated over one- and five-year time horizons. The five-year timeframe was of primary interest, given the potential for cost offsets to accrue over time and to allow a more realistic impact on the number of patients treated with the new therapy.

ICER's methods for estimating potential budget impact are described in detail elsewhere and have recently been updated.<sup>65,66</sup> The intent of our revised approach to budgetary impact is to document the percentage of patients that could be treated at selected prices without crossing a budget impact threshold that is aligned with overall growth in the US economy.

Using this approach to estimate potential budget impact, we then compared our estimates to an updated budget impact threshold that represents a potential trigger for policy mechanisms to improve affordability, such as changes to pricing, payment, or patient eligibility. As described in ICER's methods presentation (<https://icer.org/our-approach/methods-process/value-assessment-framework/>), this threshold is based on an underlying assumption that health care costs should not grow much faster than growth in the overall national economy. From this foundational assumption, our potential budget impact threshold is derived using an estimate of growth in US gross domestic product +1%, the average number of new drug approvals by the FDA over the most recent two-year period, and the contribution of spending on retail and facility-based drugs to total health care spending.

For 2021-2022, the five-year annualized potential budget impact threshold that should trigger policy actions to manage access and affordability is calculated to total approximately \$734 million per year for new drugs.