Camzyos

Qatar · access guide

How to access Camzyos for symptomatic obstructive hypertrophic cardiomyopathy from Qatar: 2026 pathway via Qatar cardiology with REMS-mandated TTE monitoring

By Reserve Meds clinical & regulatory team. Last reviewed 2026-05-20.

Qatar's cardiology reference is the Heart Hospital at Hamad Medical Corporation (HMC) in Doha, the national cardiac centre. Heart Hospital coordinates with HMC Cardiology, Aspetar Sports Medicine and Orthopaedic Hospital cardiology (for athlete-focused HCM cases), and the private-sector cardiology programmes at Doha Clinic, Al Ahli Hospital, and Hamad Medical Corporation outpatient services. Sidra Medicine is paediatric-only and is not the relevant centre for adult Camzyos. These programmes work up and follow hypertrophic cardiomyopathy through the full management ladder: lifestyle and risk-stratification, beta-blockers and non-dihydropyridine calcium channel blockers, disopyramide, septal reduction (surgical myectomy or alcohol septal ablation, typically by cross-border referral for high-volume programmes), and now first-in-class cardiac myosin inhibition with Camzyos (mavacamten, Bristol Myers Squibb). For advanced HCM care including high-volume septal reduction and high-volume cardiac myosin inhibitor experience, cross-border referral to KFSHRC Riyadh, KACC Riyadh, or Cleveland Clinic Abu Dhabi Heart and Vascular Institute is the standard pathway. For a Qatar-resident adult with confirmed symptomatic obstructive hypertrophic cardiomyopathy (oHCM) at NYHA class II or III who has not had adequate response to beta-blocker or calcium channel blocker monotherapy, the operational question is no longer whether the drug is reachable: it is whether the patient meets the strict eligibility criteria, how the prescribing cardiologist runs the REMS-equivalent echocardiography monitoring schedule, what the insurance and out-of-pocket exposure looks like in QAR, and how the family handles a multi-year course built around quarterly transthoracic echocardiograms.

This page explains how the pathway works in 2026 for a Qatar-resident patient: who qualifies, where the prescribing cardiologist conversation happens, how Camzyos is dispensed and monitored under MOPH coordination, what the dose titration and serial echocardiography schedule looks like, what the realistic annual cost band is in QAR, what to monitor (LVEF and Valsalva LVOT gradient on every scheduled TTE), and how the longer-term treatment course fits into a Qatari family's life. It is concierge documentation written for a family already in conversation with a treating cardiologist who wants the operational reality laid out plainly.

Why Camzyos, and why now

Camzyos is mavacamten, the first-in-class selective allosteric cardiac myosin inhibitor. Developed by MyoKardia and acquired by Bristol Myers Squibb. The mechanism is what distinguishes Camzyos from the rest of the HCM medical-therapy ladder: beta-blockers and calcium channel blockers reduce heart rate and contractility globally; disopyramide reduces contractility through sodium channel blockade; Camzyos selectively reduces the number of actin-myosin cross-bridges in the cardiac sarcomere, addressing the hypercontractility that drives left ventricular outflow tract (LVOT) obstruction in oHCM at its molecular root. The pivotal EXPLORER-HCM trial (placebo-controlled at week 30, published in The Lancet 2020) demonstrated meaningful reductions in post-exercise peak LVOT gradient, NYHA class improvement, and improvement in peak oxygen consumption. The SEQUOIA-HCM programme and the VALOR-HCM trial extended the evidence base including a reduction in patients meeting septal reduction therapy eligibility.

The FDA approved Camzyos in April 2022 for symptomatic obstructive hypertrophic cardiomyopathy NYHA class II to III. EMA approval followed in June 2023. MOPH registration status is verified at intake; the named-patient European-import pathway covers Qatar dispensing where in-country registration coordination is not yet complete.

For a Qatar patient with confirmed oHCM (echocardiographic LV wall thickness consistent with HCM, peak Valsalva LVOT gradient 50 mmHg or more, NYHA class II or III symptoms, LVEF 55 percent or more at baseline) who is symptomatic despite beta-blocker or calcium channel blocker therapy, Camzyos is the first oral therapy that addresses the molecular driver of the disease rather than the rate-and-contractility axis. The conversation about whether to escalate to Camzyos versus add disopyramide versus cross-border referral for septal myectomy or alcohol septal ablation is the central clinical decision. This page is the operational layer underneath that conversation.

Reserve Meds does not promote one HCM therapy over another. The page describes the Camzyos pathway because Camzyos is the drug the patient has asked about.

What Camzyos is, in plain language

Camzyos is an oral capsule taken once daily. There is no infusion centre, no inpatient stay, no injection. The starting dose is 5 mg once daily. The dose is titrated up or down within a 2.5 mg to 15 mg daily range based on the REMS-mandated transthoracic echocardiogram (TTE) schedule, which measures left ventricular ejection fraction (LVEF) and peak Valsalva LVOT gradient at baseline, week 4, week 8, week 12, and then every 12 weeks indefinitely. Treatment is paused if LVEF falls below 50 percent or if Valsalva LVOT gradient drops below 30 mmHg; treatment is resumed at a lower dose once those parameters recover.

This is not a short-course therapy. Camzyos is taken for as long as it controls the obstructive pathophysiology and the patient tolerates it. The serial TTE schedule is the central operational element of the treatment plan and is non-negotiable.

Eligibility at a Qatar cardiologist clinic

For Qatar-resident patients, the cardiology programmes apply the FDA and EMA criteria with local adaptation:

1. Confirmed obstructive hypertrophic cardiomyopathy. Echocardiographic LV wall thickness consistent with HCM (typically 15 mm or more, or 13 mm or more with family history or HCM genetic mutation), peak Valsalva LVOT gradient 50 mmHg or more at rest or with provocation, NYHA class II or III symptoms. 2. Baseline LVEF 55 percent or more on TTE. LVEF below 55 percent excludes Camzyos initiation. 3. Treatment history. Inadequate response to or intolerance of beta-blocker or calcium channel blocker monotherapy at adequate dose. Some patients may be considered after disopyramide trial. 4. Adult (18 years or older). No paediatric label for Camzyos as of 2026. Sidra Medicine is paediatric-only and is not the relevant centre for adult Camzyos. 5. Effective contraception for women of childbearing potential. Camzyos is embryo-fetal toxic; pregnancy is contraindicated. Pregnancy testing before initiation and during treatment as clinically indicated. 6. Drug-drug interaction review. Camzyos is contraindicated with strong CYP2C19 inhibitors and moderate-to-strong CYP3A4 inhibitors and inducers. Avoid grapefruit juice. A full medication review at every visit is the standard of care. 7. REMS-equivalent prescriber and pharmacy enrolment. The treating cardiologist and the dispensing pharmacy operationalise the Camzyos REMS schedule regardless of whether the formal US REMS programme applies; the serial TTE schedule is the central element.

A Qatar patient should arrive at the Camzyos conversation with the most recent cardiology documentation: TTE report with LVEF and peak Valsalva LVOT gradient measurements, cardiac MRI if available (Heart Hospital at HMC has established cardiac MRI capability), complete treatment history with response durations and reasons for failure, current medication list with attention to CYP2C19 and CYP3A4 substrates, family history of HCM and sudden cardiac death, and the insurance documentation that the prescribing office typically initiates.

The Qatar prescribing and supply picture, plainly

Camzyos MOPH registration status is verified at intake. BMS's MENA commercial supply runs through regional distributors. Where in-country registration is complete, in-country pharmacy dispensing applies. Where registration coordination is not yet complete, a named-patient European-import pathway covers the case. The pathway is:

1. **Prescribing physician**: a board-certified cardiologist with HCM programme experience. The Qatar services include Heart Hospital at Hamad Medical Corporation (the national cardiac reference), HMC Cardiology outpatient, Aspetar (for athlete-focused HCM cases), and the private-sector cardiology programmes at Doha Clinic and Al Ahli Hospital. Sidra Medicine is paediatric-only. Cross-border referral to KFSHRC Riyadh, KACC Riyadh, or Cleveland Clinic Abu Dhabi is the standard pathway for advanced HCM evaluation and high-volume cardiac myosin inhibitor experience. 2. **Pharmacy dispensing**: hospital pharmacy at Heart Hospital or the prescribing centre. Camzyos is a room-temperature oral capsule; cold-chain handling is not required. Monthly dispensing is the typical pattern. 3. **Insurance pre-authorisation**: HMC coverage for Qatari nationals extends to specialty cardiology therapy with documented severity and prior-therapy failure. Private commercial insurers (Qatar Insurance, Doha Insurance, AXA Gulf, MetLife, Cigna) require similar documentation. The prior beta-blocker or calcium channel blocker trial-and-failure documentation is the most common pre-authorisation friction point. 4. **REMS-equivalent monitoring**: the prescribing cardiologist operationalises the TTE schedule (baseline, week 4, week 8, week 12, then every 12 weeks) and the LVEF and Valsalva LVOT gradient checkpoints regardless of regulatory wrapper. This is the operational backbone of Camzyos therapy in Qatar. 5. **Ongoing follow-up**: cardiology visits coordinated with each scheduled TTE. Medication review at every visit. Pregnancy testing for women of childbearing potential per the prescribing office protocol.

Cost band and insurance positioning

US WAC for Camzyos is approximately USD 7,400 to 10,000 per month at standard maintenance dosing, with an annual cost band of approximately USD 89,000 to 120,000. At 2026 indicative cross rates, the QAR-equivalent annual cost band is approximately QAR 324,000 to 437,000. Insurance pre-authorisation reduces out-of-pocket exposure substantially for covered patients; cash-pay exposure depends on the dispensing pharmacy's regional pricing.

For Qatari nationals with HMC coverage, the financial pre-authorisation conversation needs to start before the first dispensing, not after. Commercial cover varies; the prescribing cardiologist office is the gating step.

What to expect on Camzyos, week-by-week

Week 0: Baseline TTE confirms LVEF 55 percent or more and peak Valsalva LVOT gradient 50 mmHg or more. Baseline pregnancy test for women of childbearing potential. Full medication review for CYP2C19 and CYP3A4 interactions. Camzyos 5 mg once daily started.

Week 4: TTE at week 4. LVEF and Valsalva LVOT gradient measured. If LVEF less than 50 percent or Valsalva LVOT gradient less than 30 mmHg, pause treatment. Otherwise continue 5 mg or titrate based on the prescribing cardiologist's judgement and the TTE numbers.

Week 8: TTE at week 8. Same checkpoint logic. Many patients are still at 5 mg or 10 mg at this point. Dose titration is gradual.

Week 12: TTE at week 12. Same checkpoint logic. By week 12 most patients have reached their maintenance dose between 5 mg and 15 mg daily.

Week 24, 36, 48 and onwards: TTE every 12 weeks indefinitely. Same checkpoint logic at each visit. Medication review at every visit. Pregnancy testing as clinically indicated for women of childbearing potential.

Ongoing: Maintenance dosing for as long as Camzyos controls the obstructive pathophysiology and the patient tolerates it. Quarterly cardiology follow-up minimum.

When Camzyos is the wrong drug

For a Qatar patient with baseline LVEF less than 55 percent (excludes Camzyos initiation), with planned pregnancy or inability to use effective contraception (embryo-fetal toxicity contraindication), with concurrent strong CYP2C19 inhibitor or moderate-to-strong CYP3A4 inhibitor or inducer therapy that cannot be discontinued (contraindicated combinations), or with severe symptomatic HCM that is better addressed by septal reduction (surgical myectomy or alcohol septal ablation), the operational pathway shifts:

- **Septal myectomy**: cross-border referral to KFSHRC Riyadh, KACC Riyadh, Cleveland Clinic Abu Dhabi, or international high-volume centres. Established gold standard for selected oHCM patients. - **Alcohol septal ablation**: cross-border referral to KFSHRC, KACC, or CCAD interventional cardiology. Catheter-based alternative to surgical myectomy for selected patients with suitable septal perforator anatomy. - **Disopyramide**: oral antiarrhythmic with negative inotropic effect, used as an add-on to beta-blocker for symptom control in oHCM. Class IA antiarrhythmic considerations apply. - **Continued beta-blocker or calcium channel blocker optimisation**: where the prescribing cardiologist judges the trial inadequate or doses suboptimal. - **Aficamten (Cytokinetics, second cardiac myosin inhibitor, post-Phase III)**: not yet commercially available, but in late-stage development. Patients may wish to discuss timing.

Reserve Meds does not promote one HCM therapy over another. If the conversation with the treating cardiologist points toward septal reduction therapy, disopyramide, continued conventional medical therapy, or watchful waiting for aficamten, the operational pathway shifts accordingly.

What Reserve Meds does on this case

We are a US-based concierge coordinator. We are not the prescriber and not the dispensing pharmacy. On a Qatar Camzyos case we build the documentation pack with the treating cardiologist office (typically at Heart Hospital at HMC, HMC Cardiology, Aspetar, or private-sector cardiology), confirm MOPH registration status and the appropriate dispensing pathway, run the insurance pre-authorisation conversation alongside the clinical pre-authorisation conversation, coordinate the supply logistics for monthly dispensing, organise scheduling for the baseline, week 4, week 8, week 12, and quarterly TTEs (including cross-border coordination with KFSHRC, KACC, or CCAD where advanced HCM care is indicated), and stay with the case through the first year of dosing with handoff to the local cardiologist for ongoing surveillance. Clinical decisions remain with your treating cardiologist.

Reserve Meds's role

US-based concierge coordinator for cross-border specialty medicine. We are not the prescriber, not the dispensing pharmacy, and not the manufacturer. All clinical decisions remain with your treating physician.

Composite case examples. This document is for general information only and does not constitute medical advice. Please consult your treating physician.
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