

## CAMZYOS® REMS Healthcare Provider Designee Enrollment Form

To enroll online, ask the healthcare provider to invite you to enroll via the My Teams feature of their dashboard, found at [CAMZYOSREMS.com](http://CAMZYOSREMS.com).

To enroll via fax, please complete all required fields and fax this form to 833-299-9539.

Once you have been invited or your fax has been processed, you will receive an email with a link that will allow you to create website credentials.

### Healthcare Provider Acknowledgment

As a certified Healthcare Provider, I may designate a member of my staff who is a licensed medical professional to be my Designee. This Designee can perform REMS activities for me in the CAMZYOS REMS.

I am responsible for all information entered and activities performed in the CAMZYOS REMS by the Designee.

**Initial and subsequent prescriptions for CAMZYOS must be written by a certified healthcare provider.**

<b>Certified Healthcare Provider Information</b> (Fields marked * are REQUIRED)	
*First Name:	*Last Name:
*Healthcare Provider NPI #:	*Phone:  <div style="text-align: right; font-size: small;">Area Code/Telephone Number</div>
*Healthcare Provider Signature: _____ *Date: _____ <div style="text-align: right; font-size: small;">Month/Day/Year</div>	

### Designee Acknowledgment

By signing this form, I acknowledge that I will act on behalf of the certified Healthcare Provider identified above. I have reviewed the [Prescribing Information](#), the [Education Program for Healthcare Providers and Pharmacies](#), and the [Program Overview](#).

As a Healthcare Provider Designee, I acknowledge that I can do the following:

- Counsel the patient, using the [Patient Brochure](#), before and throughout treatment on the:
  - risk of heart failure due to systolic dysfunction, including how to recognize and respond to the symptoms of heart failure due to systolic dysfunction
  - risk of drug-drug interactions with CYP2C19 and CYP3A4 inhibitors and inducers and the need to inform healthcare providers of all the prescription and nonprescription medication they take
- Provide the patient with the [Patient Brochure](#)
- Assess the patient’s cardiovascular status and the appropriateness of initiating treatment by obtaining a baseline echocardiogram
- Assess the patient’s prescription and nonprescription medications and supplements for drug-drug interactions



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# CAMZYOS® REMS

## Healthcare Provider Designee Enrollment Form

- Document and submit confirmation of an echocardiogram, assessment of drug-drug interactions, and authorization for treatment to the REMS using the ***Patient Enrollment Form***
- During treatment, assess the patient’s cardiovascular status and the appropriateness of continuing treatment by echocardiogram and document and submit confirmation of an echocardiogram, assessment of drug-drug interactions, and authorization for continuing treatment to the REMS using the ***Patient Status Form***

<b>Designee Information</b> (Fields marked * are REQUIRED)		
*First Name: _____	Middle Initial: _____	*Last Name: _____
*Phone: _____ <small style="text-align: center;">Area Code/Telephone Number</small>	*Fax: _____ <small style="text-align: center;">Area Code/Fax Number</small>	
*Email: _____	Preferred Method of Contact (please select one): <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Fax	
*Role (must be one of the following medical professionals): <input type="checkbox"/> RPh/PharmD <input type="checkbox"/> RN <input type="checkbox"/> NP <input type="checkbox"/> PA		
*Designee Signature: _____		*Date: _____ <small style="text-align: right;">Month/Day/Year</small>



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**Fax: 833-299-9539**  
**CAMZYOSREMS.com**