CAMZYOS™ (mavacamten) 2.5, 5, 10, 15mg capsules

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.

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.

Certified Healthcare Provider Information (Fields marked * are REQUIRED)	
*First Name:	*Last Name:
*Healthcare Provider NPI #:	*Phone: Area Code/Telephone Number
***Healthcare Provider Signature:** _____ ***Date:** _____ Month/Day/Year	

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:
  - serious 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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Phone: 833-628-7367
Fax: 833-299-9539
CAMZYOSREMS.com

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- 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**

Designee Information
(Fields marked * are REQUIRED)

*First Name:	Middle Initial:	*Last Name:
*Phone: _____ Area Code/Telephone Number		*Fax: _____ Area Code/Fax Number
*Email:		Preferred Method of Contact (please select one): ☐ Phone ☐ Email ☐ Fax
*Role (must be one of the following medical professionals): ☐ RPh/PharmD ☐ RN ☐ NP ☐ PA		

By signing below, I acknowledge the above agreements and my obligations as a CAMZYOS Healthcare Provider Designee to comply with CAMZYOS REMS requirements, and I understand my personally identifiable information provided above will be shared with Bristol Myers Squibb (BMS), its agents, contractors, and affiliates and entered into a database for the CAMZYOS REMS. I agree that I may be contacted in the future by mail, email, fax, and/or phone concerning CAMZYOS, the CAMZYOS REMS, and other CAMZYOS programs and services. For more information on BMS' commitment to privacy and its collection and processing of personal data, please visit https://www.bms.com/privacy-policy.html.

***Designee Signature:** _____ ***Date:** _____ Month/Day/Year

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