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

CAMZYOS® REMS
Patient Status Form

To Be Completed by a Certified Healthcare Provider or a Designee

Submit this form to the CAMZYOS REMS after each required echocardiogram based on the **Prescribing Information**.

- ▶ Complete the form online at **CAMZYOSREMS.com**, or
- ▶ Print and fax the completed form to the CAMZYOS REMS at 833-299-9539

This form must be submitted in its entirety on the appropriate REMS program schedule in order for your patient to receive CAMZYOS. Failure to submit the Patient Status Form may result in dispensing holds and potentially treatment interruptions.

Echocardiograms must be done:

Before treatment starts	**At 4 weeks** after treatment is started	**At 8 weeks** after treatment is started	**At 12 weeks** after treatment is started	**Every 3 to 6 months** thereafter (depending on echocardiogram results)

Alternative echocardiogram schedules may be implemented based on the below scenarios.

- With any dose change:
  - Perform an echocardiogram 4 and 12 weeks later
  - Resume monitoring per the **Prescribing Information**
- With any treatment discontinuation due to LVEF <50%, perform an echocardiogram 4 weeks later
  - If treatment is reinitiated, perform an echocardiogram 4 and 12 weeks later
  - Continue performing echocardiograms every 3 to 6 months (depending on echocardiogram results)
- With initiation of a weak to moderate CYP2C19 inhibitor or a moderate to strong CYP3A4 inhibitor:
  - Perform an echocardiogram 4 weeks after initiation
  - Perform an echocardiogram 12 weeks after initiation
  - Continue performing echocardiograms every 3 to 6 months thereafter (depending on echocardiogram results)

For internal use only

Bristol Myers Squibb®

© 2026 MyoKardia, Inc., a Bristol Myers Squibb company.
CAMZYOS® and the CAMZYOS Logo are trademarks of MyoKardia, Inc.
3500-US-2600526 09/26

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

CAMZYOS® REMS
Patient Status Form

Patient Information
(Fields marked * are REQUIRED)

*Patient First Name:	Middle Initial:	*Last Name:
*Birthdate (MM/DD/YYYY):	Phone: Area Code/Telephone Number	

Healthcare Provider Information
(Fields marked * are REQUIRED)

*Healthcare Provider First Name:	*Last Name:
*Healthcare Provider NPI #:	*Phone: Area Code/Telephone Number
*Fax: Area Code/Fax Number	*Email:

*Healthcare Provider Agreement

☐ I acknowledge that I have counseled the patient 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

☐ I acknowledge that the **Prescribing Information** states that the patient should receive echocardiograms.

☐ I acknowledge that I have assessed the patient's prescription and nonprescription medications and supplements for drug-drug interactions.

For internal use only

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

Bristol Myers Squibb®
© 2026 MyoKardia, Inc., a Bristol Myers Squibb company.
CAMZYOS® and the CAMZYOS Logo are trademarks of MyoKardia, Inc.
3500-US-2600526 09/26

CAMZYOS® REMS
Patient Status Form

*Patient Monitoring

1. I have reviewed the patient's echocardiogram report (Echo Performed Date: _____).
   Month/Day/Year
   ☐ Yes ☐ No (If no, the patient cannot receive CAMZYOS)

2. What is the patient's Valsalva LVOT?
   ☐ <20 mmHg ☐ ≥20 mmHg and <30 mmHg ☐ ≥30 mmHg
   Note: Assessment of postexercise LVOT gradient may be considered in symptomatic patients with normal or near-normal Valsalva gradients prior to initiating treatment with CAMZYOS.

3. What is the patient's LVEF?
   ☐ <50% (If <50%, CAMZYOS therapy must be interrupted) ☐ 50-<55% ☐ ≥55%

4. For this clinical visit, what action was taken with the patient's dose of CAMZYOS?
   ☐ No change ☐ Dose decrease ☐ Dose increase ☐ Dose interruption

5. Did the patient experience a clinical heart failure event requiring hospitalization?
   ☐ Yes ☐ No

6. After review of the patient's prescription and nonprescription medications and supplements, does the patient require a dose adjustment due to a potential drug-drug interaction?
   ☐ Yes ☐ No

7. Is the patient authorized to continue treatment?
   ☐ Yes ☐ No

***Healthcare Provider or Designee Signature:** _____ ***Date:** _____
Month/Day/Year

Print Name: _____

Note: A CAMZYOS REMS–certified healthcare provider or healthcare provider designee may complete and submit this form on behalf of the certified healthcare provider of record. The certified healthcare provider of record is responsible for compliance with the REMS requirements, including monitoring, evaluation, and management of each patient under his/her care.

If you have questions about the REMS, please call the CAMZYOS REMS Call Center at 833-628-7367, 8:00 AM–8:00 PM ET.

To report SUSPECTED ADVERSE REACTIONS, contact Bristol Myers Squibb at 800-721-5072 and medical.communications@bms.com.

For internal use only

Bristol Myers Squibb®

© 2026 MyoKardia, Inc., a Bristol Myers Squibb company.
CAMZYOS® and the CAMZYOS Logo are trademarks of MyoKardia, Inc.
3500-US-2600526 09/26

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