

CAMZYOS® REMS Pharmacy Enrollment Form

Instructions:

- Review the **Prescribing Information**, the **Education Program for Healthcare Providers and Pharmacies**, and the **Program Overview**
- Successfully complete and submit the **Pharmacy Authorized Representative Knowledge Assessment** and the **Pharmacy Enrollment Form** to the CAMZYOS REMS:
 - Online at **CAMZYOSREMS.com**, or
 - By fax at 833-299-9539

Complete all required fields on this form to avoid a delay in the enrollment process. Upon completion of these steps, the REMS will notify you of your successful certification within 1 business day.

Pharmacy Information (Fields marked * are REQUIRED)			
*Pharmacy Name:	*Pharmacy NPI #:	*Pharmacy DEA #:	
*Pharmacy Address:	*City:	*State:	*ZIP Code:
*Phone: _____		*Fax: _____	
Area Code/Telephone Number		Area Code/Fax Number	

Authorized Representative Information (Fields marked * are REQUIRED)		
*First Name:	Middle Initial:	*Last Name:
*Title/Position:		
*Phone: _____	*Fax: _____	
Area Code/Telephone Number Area Code/Fax Number		
*Email:		
Preferred Method of Contact (please select one): ☐ Phone ☐ Email ☐ Fax		

*Secondary Contact (Fields marked * are REQUIRED)		
*First Name:	Middle Initial:	*Last Name:
*Phone: _____	*Fax: _____	
Area Code/Telephone Number Area Code/Fax Number		
*Email:		



For internal use only

CAMZYOS® REMS

Pharmacy Enrollment Form

Pharmacy Agreements

As the Authorized Representative, I must:

- Review the [Prescribing Information](#), the [Education Program for Healthcare Providers and Pharmacies](#), and the [Program Overview](#)
- Successfully complete the [Pharmacy Authorized Representative Knowledge Assessment](#) and submit it to the CAMZYOS REMS
- Enroll in the REMS by completing and submitting the [Pharmacy Enrollment Form](#) to the REMS
- Train all relevant staff involved in dispensing CAMZYOS using the [Program Overview](#) and the [Education Program for Healthcare Providers and Pharmacies](#)

Before dispensing, all pharmacy staff must:

- Counsel the patient on drug-drug interactions
- Assess the patient's prescription and nonprescription medications and supplements for drug-drug interactions. Document and submit to the CAMZYOS REMS using the [Drug Interaction and Counseling Checklist for Pharmacies](#)
- Document the prescribed dose of CAMZYOS
- Obtain authorization to dispense each prescription by contacting the CAMZYOS REMS to verify that the:
 - prescriber is certified and the patient is enrolled
 - healthcare provider has authorized the patient to receive the drug, the patient is counseled, and the pharmacy has identified and resolved any drug-drug interactions
- Provide the patient with the [Patient Brochure](#)
- Dispense no more than a 35-day supply of CAMZYOS to patients in their first year of treatment
- Dispense no more than a 90-day supply of CAMZYOS to patients beyond their first year of treatment
- For patients who delay treatment initiation up to 90 days from [Patient Enrollment Form](#) submission: Assess the patient's treatment start date. Document and submit the new start date using the REMS website

At all times, all pharmacy staff must:

- Report adverse events of heart failure due to systolic dysfunction to Bristol Myers Squibb
- Not distribute, transfer, loan, or sell CAMZYOS except to a certified pharmacy
- Maintain records of dispensing information
- Maintain records of completion of the REMS training by relevant staff
- Maintain records that all processes and procedures are in place and are being followed
- Comply with audits carried out by Bristol Myers Squibb or a third party acting on behalf of Bristol Myers Squibb to ensure that all processes and procedures are in place and are being followed

To maintain certification to dispense, any new Authorized Representative must:

- Enroll in the CAMZYOS REMS by successfully completing the [Pharmacy Authorized Representative Knowledge Assessment](#) and completing the [Pharmacy Enrollment Form](#)

By signing below, I acknowledge the above agreements and my obligations as a CAMZYOS Pharmacy Authorized Representative 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>.

***Authorized**

Representative Signature: _____

***Date:** _____

Month/Day/Year

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