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

CAMZYOS™ REMS
Patient Enrollment Form

- Complete this form online at **CAMZYOSREMS.com**, or
- Print and complete this form and submit by fax to the CAMZYOS REMS at 833-299-9539

Patient Information
(Fields marked * are REQUIRED)

*First Name:	Middle Initial:	*Last Name:
*Date of Birth: Month/Day/Year		*Gender: ☐ Female ☐ Male ☐ Neutral ☐ Prefer Not to Say

*Address:	*City:	*State:	*ZIP Code:

*Phone: Area Code/Telephone Number	Alternate Phone (optional): Area Code/Telephone Number
*Email:	Preferred Method of Contact: ☐ Phone ☐ Email
Person to Contact if Patient Is Not Available/Secondary Contact:	Phone Number for Secondary Contact: Area Code/Telephone Number

Certified Healthcare Provider Information
(Fields marked * are REQUIRED)

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

For patients who are participating or have finished participation in a clinical trial for CAMZYOS

Will the patient now be enrolling in the REMS on a dose higher than expected for new patients?

☐ Yes ☐ No

For internal use only

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

Patient Agreement

- I have received, read, and understand the ***Patient Brochure*** that my healthcare provider has given me

Before treatment, I will:

- Enroll in the CAMZYOS REMS by completing this ***Patient Enrollment Form*** with my healthcare provider
- Get an echocardiogram (echo) to check my heart as directed by my doctor

My healthcare provider has counseled me, using the *Patient Brochure*, on:

- The risk of heart failure due to systolic dysfunction (when the heart cannot pump enough blood to the body)
- The risk of drug-drug interactions and the need to inform healthcare providers of all the prescription and over-the-counter medicines and supplements I take
- The need for echos during my treatment with CAMZYOS

I understand the symptoms of heart failure, including:

- shortness of breath
- chest pain
- fatigue
- a racing sensation in your heart (palpitations)
- swelling in your legs
- rapid weight gain

During treatment, I will:

- Continue to receive counseling from my healthcare provider using the ***Patient Brochure*** on:
  - the risk of heart failure due to systolic dysfunction (when the heart cannot pump enough blood to the body)
  - the risk of drug-drug interactions and the need to inform healthcare providers of all the prescription and over-the-counter medicines and supplements I take
- Get echos to check my heart as directed by my doctor

Before I receive each prescription:

- I will review all my prescription and over-the-counter medicines and supplements with the pharmacist
- The pharmacist will counsel me on drug-drug interactions

At all times, I will:

- Inform my healthcare provider or seek other medical attention if I have new or worsening symptoms of heart failure
- Inform all my healthcare providers that I am taking CAMZYOS
- Inform healthcare providers of all medicines, including over-the-counter medicines and supplements and any changes to my medicines

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CAMZYOS™ REMS
Patient Enrollment Form

Patient Agreement (continued)

- I understand that my protected health information will be stored in a secure and confidential database of all patients who receive CAMZYOS in the United States
- Bristol Myers Squibb and its agents will use and share my protected health information for the CAMZYOS REMS program and for FDA reporting
- I agree that Bristol Myers Squibb and its agents may contact me by phone, mail, or email to manage the CAMZYOS REMS

***Patient/Legal Guardian Signature:** _____ ***Date:** _____
Month/Day/Year

Print Name: _____

Healthcare Provider Acknowledgment

- I have reviewed the echocardiogram result for this patient and confirmed that it is appropriate to initiate treatment with CAMZYOS (LVEF ≥55%): Echo Performed Date: _____
Month/Day/Year

  The VLVOT for this patient is: ☐ <20 mmHg ☐ ≥20 mmHg and <30 mmHg ☐ ≥30 mmHg

- I have reviewed the patient's prescription and nonprescription medications and supplements for drug-drug interactions
  - After reviewing the patient's prescription and nonprescription medications and supplements, does the patient require a lower starting dose due to a potential drug-drug interaction?

    ☐ Yes ☐ No
- I have provided the ***Patient Brochure*** to the patient
- The patient is authorized to begin treatment

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

Print Name: _____

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Bristol Myers Squibb™

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