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

Is the patient transitioning from a clinical trial for CAMZYOS? ☐ Yes ☐ No

If "yes" is selected, the CAMZYOS REMS may verify the patient's participation in a clinical trial for CAMZYOS.

If yes:

1. From which clinical trial is the patient transitioning? ☐ VALOR-HCM ☐ EXPLORER-LTE ☐ PIONEER-OLE
2. Based on their dose of CAMZYOS in the clinical trial, will the patient be enrolling in the REMS on a dose different than expected for new patients (ie, 5 mg)? ☐ Yes ☐ No
3. Is the patient on a stable dose* from the clinical trial? ☐ Yes (continue to A. below) ☐ No (continue to B. below)

**A patient is on a stable dose if they are on the same dose of CAMZYOS for the last 12 weeks of their clinical trial dosing and if there are 8 weeks or less between exit from the clinical trial and enrollment into the REMS.*

A. Since your patient is on a stable dose of CAMZYOS from the clinical trial, they are able to initiate treatment by following the monitoring schedule described in "Figure 2: Maintenance Phase" in the *Prescribing Information.*
Patient Status Form submission is required 6 months from the first REMS dispense, then every 3 to 6 months from the Echo Performed Date reported on the latest Patient Status Form.

B. Submission of the Patient Status Form is required at 4 weeks, 8 weeks, and 12 weeks following transition from the clinical trial, then every 3 to 6 months from the Echo Performed Date reported on the latest *Patient Status Form*. LVEF must be ≥50% to continue treatment under the CAMZYOS REMS.

For internal use only

Bristol Myers Squibb®

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

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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
- Notify my healthcare provider if I delay taking my first dose of CAMZYOS more than 7 days after receiving my first prescription of CAMZYOS from the pharmacy

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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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
  *If the patient is transitioning from a clinical trial to the REMS on a stable dose, LVEF ≥50% is appropriate.
  - 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, is the patient currently on stable therapy with a moderate CYP2C19 or a strong CYP3A4 inhibitor?
    ☐ **Yes** (If Yes, initiate CAMZYOS at 2.5 mg) ☐ **No**
    - If yes, please provide the medication(s)

      _____
- **I have provided the *Patient Brochure* to the patient**
- **The patient is authorized to begin treatment**

[Optional]
If the patient will not start taking CAMZYOS upon receipt of their first prescription from the pharmacy, please indicate the date the patient will start taking CAMZYOS (date must not be later than 90 days from the submission of this ***Patient Enrollment Form***):

Treatment Start Date: _____ Month/Day/Year

Reason (select only one):

☐ Healthcare provider instruction ☐ Drug-drug interaction resolution
☐ Echocardiogram schedule delay ☐ Illness ☐ Patient decision

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

Print Name: _____

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