

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): <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> 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 Responsibilities

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
- 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
- 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
- Have a new authorized representative enroll in the CAMZYOS REMS by successfully completing the **Pharmacy Authorized Representative Knowledge Assessment** and completing the **Pharmacy Enrollment Form**

***Authorized Representative Signature:** _____ ***Date:** _____
Month/Day/Year



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CAMZYOSREMS.com