

! Fields marked with (!) are required to process form, including patient signature on page 4.

| PATIENT INFORMATION | | | | |
|---|-----|----------------------------------|--|--|
| ! First Name: | MI: | ! Last Name: | ! DOB (mm/dd/yyyy): | ! Gender: <input type="radio"/> M <input type="radio"/> F |
| ! Address: | | ! City: | ! State: | ! Zip: |
| Email: (IMPORTANT FOR OBTAINING PATIENT CONSENT) | | ! Preferred Phone Number: | <input type="radio"/> OK to Leave a Detailed Voicemail | |
| Care Partner First Name: | | | Last Name: | |
| Phone: | | Email: | Preferred Language: | |

| INSURANCE INFORMATION | | | | |
|---|-----------------------------------|--|-----------------------------------|--|
| <input type="radio"/> PRESCRIPTION DRUG INSURANCE Check box and attach front and back copies of prescription insurance card OR complete information below. | | <input type="radio"/> MEDICAL INSURANCE Check box and attach front and back copies of medical insurance card OR complete information below. | | |
| ! Primary Insurance Carrier: | | ! Primary Insurance Carrier: | | |
| Phone: | | Phone: | | |
| ! Member ID #: | ! Group #: | ! Policy ID #: | Group #: | |
| ! Rx BIN #: | Rx PCN #: | ! Policy Holder First Name: | | |
| ! Policy Holder First Name: | ! Policy Holder Last Name: | | ! Policy Holder Last Name: | |
| <input type="radio"/> Check here if patient does not have prescription insurance | | <input type="radio"/> Check here if patient does not have medical insurance | | |
| Secondary/Supplemental Insurance: | | Secondary/Supplemental Insurance: | | |
| Phone: | | Phone: | | |
| Member ID #: | Group #: | Policy ID #: | Group #: | |
| Rx BIN #: | Rx PCN #: | Policy Holder First Name: | | |
| Policy Holder First Name: | Policy Holder Last Name: | | Policy Holder Last Name: | |

| FINANCIAL INFORMATION | | | | |
|--|--|--|--|--------------------------------------|
| (Required if requesting research for alternative coverage support programs) | | | | |
| Total number of people in household (including applicant): | | Household Income: <input type="radio"/> Yearly: \$ | | or <input type="radio"/> Monthly: \$ |

Your application may be subject to audit or request for additional documentation.

INDICATION

CAMZYOS® (mavacamten) is indicated for the treatment of adults with symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy (HCM) to improve functional capacity and symptoms.

IMPORTANT SAFETY INFORMATION

WARNING: RISK OF HEART FAILURE

CAMZYOS reduces left ventricular ejection fraction (LVEF) and can cause heart failure due to systolic dysfunction.

Echocardiogram assessments of LVEF are required prior to and during treatment with CAMZYOS. Initiation of CAMZYOS in patients with LVEF

<55% is not recommended. Interrupt CAMZYOS if LVEF is <50% at any visit or if the patient experiences heart failure symptoms or worsening clinical status.

Concomitant use of CAMZYOS with certain cytochrome P450 inhibitors or discontinuation of certain cytochrome P450 inducers may increase the risk of heart failure due to systolic dysfunction; therefore, the use of CAMZYOS is contraindicated with the following:

- Moderate to strong CYP2C19 inhibitors or strong CYP3A4 inhibitors
- Moderate to strong CYP2C19 inducers or moderate to strong CYP3A4 inducers

Because of the risk of heart failure due to systolic dysfunction, CAMZYOS is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the CAMZYOS REMS PROGRAM.

Please see additional Important Safety Information throughout and **U.S. Full Prescribing Information**, including **Boxed WARNING** and **Medication Guide**.

PHYSICIAN INFORMATION

| | | |
|----------------------------------|------------------------------|----------------------|
| ① Treating Physician First Name: | ① Last Name: | ① NPI #: |
| Practice/Facility: | ① Phone: | ① Fax: |
| ① Address: | ① City: | ① State: ① Zip: |
| Office Contact First Name: | Last Name: | Title: |
| Office Contact Email: | Phone: | Fax: |
| Referring Physician Name: | Referring Physician Address: | |
| | City: | State: Zip: |

ECHOCARDIOGRAM BENEFITS INVESTIGATION

(If eligible, all commercially insured patients will be enrolled in the CAMZYOS Echocardiogram Co-Pay Assistance Program.)

Request Echocardiogram Benefits Investigation ① CPT Code: _____
(Echocardiogram Procedure Code required for Medical Benefits Investigation)

Provider Transaction Access Number (PTAN): _____ Tax ID #: _____
(PTAN and Tax ID number are required for Medical [echocardiogram] Benefit Investigation for Medicare patients.) PTAN can be found by logging into <https://pecos.cms.hhs.gov/pecos/login.do#headingLv1>

PRESCRIPTIONS (Check all prescriptions that apply)

Only healthcare providers certified in the CAMZYOS® (mavacamten) Risk Evaluation and Mitigation Strategy (REMS) program are authorized to prescribe CAMZYOS.

① Patient First Name: _____ MI: _____ ① Last Name: _____ ① DOB (mm/dd/yyyy): _____

① ICD-10 Diagnosis Code No Known Drug Allergies (NKDA)

I42.1 Obstructive Hypertrophic Cardiomyopathy Drug and Non-Drug Allergies: _____

Other: _____

The patient is taking the following interacting medication(s), but is stable on this therapy and can start CAMZYOS: _____

| | | |
|--|---|--|
| <p>1 35-Day FREE TRIAL OFFER* (FTO) Available in 5 mg only. All eligible patients will be enrolled in FTO unless OPT OUT is checked.</p> <p>OR</p> <p><input type="radio"/> CAMZYOS 5 mg FREE TRIAL Rx 1 capsule orally once daily, 35 day supply</p> <p><input type="radio"/> FREE TRIAL OPT OUT Check here if patient is currently taking CAMZYOS or you do not want patient to receive Free Trial Offer.</p> | <p>2 SELECT BRIDGE For commercially insured patients with delayed coverage determination</p> <p><input type="radio"/> CAMZYOS 5 mg BRIDGE Rx 1 capsule orally once daily, 30 day supply Refills: _____</p> <p>Prescription dosage will be verified for titration prior to dispense and a new prescription may be needed.</p> | <p>3 SELECT SPECIALTY PHARMACY Sent to pharmacy when patient is triaged</p> <p><input type="radio"/> CAMZYOS 5 mg Specialty Pharmacy Rx 1 capsule orally once daily, 30 day supply Refills: _____</p> <p>Prescription dosage will be verified for titration prior to dispense and a new prescription may be needed.</p> |
|--|---|--|

Preferred Specialty Pharmacy: _____

*Program requirements and patient eligibility rules apply. Program Terms and Conditions on page 8.

PHYSICIAN CERTIFICATION

PHYSICIAN CERTIFICATION: I certify to the following: (1) to the best of my knowledge, the information that I provide to BMS in this form is complete and accurate; (2) I understand that the information provided will be used by the program for purposes of verifying my patient's insurance coverage and eligibility, assistance with prior authorization, researching alternative insurance coverage options, and transmitting the above prescriptions pursuant to applicable law to the appropriate specialty pharmacies; (3) I have the authority to disclose this patient's information to BMS and its respective agents and assignees, and I have obtained this patient's authorization for the disclosure, if required by HIPAA or other applicable privacy laws; (4) treatment with the above medication is medically necessary and for an FDA-approved use; and (5) I understand the information I provide may be used by BMS and parties acting on its behalf for services, communications, marketing, and analytics activities.

I certify, if the patient is enrolled in CAMZYOS Echocardiogram Co-Pay Assistance, to the following:

- I have read and will comply with the Program Terms and Conditions on page 8
- To the best of my knowledge, this patient satisfies the Patient Eligibility requirements, and I will notify the Program immediately if the patient's insurance status changes
- To the best of my knowledge, participation in this Program is not inconsistent with any contract or arrangement with any third-party payer to which this office/site will submit a bill or claim for reimbursement for the echocardiogram assessment administered to the patient
- I will not submit an insurance claim or other claim for payment to any third-party payer (private or government) for the amount of assistance that my patient receives from the Program
- If this office/site receives payment directly from the Program for this patient, the office/site will not accept payment from the patient for the amount received from the Program

I understand that BMS (1) may verify all information provided, and not allow or suspend participation if inadequate information is received; (2) may modify, limit, or terminate these programs, or recall or discontinue medications, at any time without notice; and (3) is relying on these certifications.

① PRESCRIBER SIGNATURE _____ OR _____ ① Date _____
Dispense as written Substitutions allowed

Please see additional Important Safety Information throughout and **U.S. Full Prescribing Information**, including **Boxed WARNING** and **Medication Guide**.

PATIENT AUTHORIZATION & AGREEMENT

MyCAMZYOS is a support program for patients by Bristol-Myers Squibb Company (BMS). Through this authorization and agreement, I choose to participate in MyCAMZYOS Access Assistance, which helps patients understand their insurance coverage and financial support options for CAMZYOS[®] (mavacamten) as well as provides echocardiogram co-pay assistance and/or free medication to those who qualify. I also have the option to participate in MyCAMZYOS MyNurse Navigator by separately enrolling below. To participate in MyCAMZYOS Access Assistance (the “Program”), BMS will need to receive, use, and disclose your personal information. Please read this authorization carefully and contact the Program at 1-855-226-9967 if you have any questions.

1. What information will be used and disclosed?

My personal information will be disclosed, including:

- Information on the Program enrollment form
- My contact information
- Date of birth
- Financial and income information
- Insurance benefit information
- Health records and information, including diagnoses, medications, and lab tests
- Biometric and genetic information, including tests that identify the kind of illness that I have and/or medication indicated for my treatment

2. Who will disclose, receive, and use the information?

This authorization permits my caretakers, which includes my healthcare providers, pharmacies, health plans or insurers who provide services to me, as well as other people that I say can help me apply (my “Health Caretakers”), to disclose my personal information to BMS, the third parties it works with, and its authorized agents, subsidiaries, and assignees (collectively “BMS”). BMS may also share my information with my Health Caretakers and with other healthcare providers, pharmacists, health insurers, and charitable organizations to determine if I am eligible for, or enrolled in, another plan or program.

3. What is the purpose for the use and disclosure?

My personal information will be used by and shared with BMS and my Health Caretakers to:

- Process my application for the Program and provide the Program services to me, including verifying my insurance benefits, assistance with prior authorizations from my insurance, researching alternative insurance coverage options, and referring me and my Health Caretakers to other plans, support, or assistance programs that may be able to help me
- Provide echocardiogram co-pay assistance and/or free medication to me, if I qualify, as further described on page 4
- Receive, and/or purchase, my information (including information about my prescriptions and insurance claims) from my Health Caretakers to determine if and where I am receiving my medication and whether I am no longer eligible for free medication or other BMS support programs
- Contact me and my Health Caretakers about other programs and services that are available or that I'm enrolled in, including screenings for or participation in other financial support options such as medication copay assistance
- Contact other healthcare providers and charitable organizations to determine if I am eligible for, or enrolled in, another plan or program
- Contact me for marketing purposes, including providing me with information about my medication, refill reminders, surveys, and other information and alerts that BMS believes may be of interest to me (and some of which may be sent directly to my phone if I choose)
- Improve or develop the Program’s services and other internal business purposes including analytics
- BMS also may use my health information to combine it with other information BMS may collect about me and my CAMZYOS treatment and use it for the purposes described above

Authorization for Sale of My Information to BMS: I authorize my Health Caretakers (including my healthcare providers, health plans, health insurers, pharmacies, lab service providers, and diagnostic service providers) to disclose my information for the purposes described in this authorization, and I further authorize my Health

(continued on next page)

Please see additional Important Safety Information throughout and **U.S. Full Prescribing Information**, including **Boxed WARNING** and **Medication Guide**.

PATIENT AUTHORIZATION & AGREEMENT (cont.)

Caretakers to accept payment from BMS in exchange for providing my information as well as providing me with marketing and patient support services.

4. When will this authorization expire?

This authorization will be effective for 5 years unless it expires earlier by law or I cancel it in writing. I may cancel this authorization for the Program by writing to:

Bristol Myers Squibb
PO BOX 1029
COLUMBUS, OH 43216

If I cancel this authorization, I will no longer be able to participate in the Program. The Program will stop using or disclosing my information for the purposes listed in this authorization, except as necessary to end my participation or as required or allowed by law.

5. Notices:

I understand that once my health information has been disclosed, privacy laws may no longer restrict its use or disclosure. BMS may use and disclose my information for the purposes described in this authorization or as allowed or required by law. I understand that BMS does not sell or rent personal information collected

about me from this Program. I have a right to receive a copy of this authorization after I have signed it. I further understand that I may refuse to sign this authorization and that if I refuse, my eligibility for health plan benefits and treatment by my healthcare providers will not change, but I will not have access to the Program services. I understand that certain state laws may allow for the right to request access to, or deletion of, my information. I understand that these state rights are not absolute and only apply in certain circumstances. Therefore, I acknowledge that I may not receive a response to my request to the extent required or permitted under relevant laws. I agree that I may need to provide additional information in order to verify my identity, such as a government-issued ID, before BMS will honor a request to provide access to, or deletion of, my information. I will not be discriminated against for exercising my rights, but I understand that I may not be able to receive Program services if I do not allow use of my information.

To submit an access or deletion request, I may call 1-855-961-0474 or complete the online form at www.bms.com/dpo/us/request.

I HAVE READ THIS AUTHORIZATION AND AGREE TO ITS TERMS:

Check here if you are a Patient Representative

i Print Name of Patient or Patient Representative:

i Representative Phone Number:

Representative's Relationship to Patient:

Preferred Email:

i SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE

i Date:

Power of Attorney documentation is required if someone other than the patient signs. You may fax the documents to 1-833-302-1421 or call 1-855-226-9967 for further assistance.

Program Terms: In order to provide Access Assistance, patients must provide information that is true and complete. At any time during participation, BMS may request additional documentation to verify the patient's personal information. If there is missing information or the patient does not respond to requests for additional information, BMS may delay or terminate participation. Additional terms apply for copay assistance and free medication. BMS may discontinue the Program or change the rules for participation at any time, without any notice.

The patient or his/her personal representative must be provided with a copy of this Patient Authorization after it has been signed.

Please see additional Important Safety Information throughout and **U.S. Full Prescribing Information**, including **Boxed WARNING** and **Medication Guide**.

MYCAMZYOS NURSE NAVIGATOR PATIENT ENROLLMENT

MyCAMZYOS MyNurse Navigator is a support program that provides patients with information and services related to CAMZYOS® (mavacamten) and related disease information including medication copay assistance for qualifying patients, refill and appointment reminders, surveys, and other information and alerts. By signing below, I agree to enroll in MyCAMZYOS MyNurse Navigator. Additional terms for copay assistance apply. See page 8 for details.

I understand that the information I provide, along with information about my use of the support program services will be stored and used by Bristol Myers Squibb and parties acting on its behalf ("BMS") to provide the support services to me and the care partners that I otherwise designate in writing. BMS may also store and use my information to contact me and my care partners via mail, telephone, in electronic format or otherwise about products, services, market research, clinical trials, and other information and offers that it believes to be of interest to me. BMS may also use my information in order to improve or develop its services and for other internal business purposes including analytics, communication services, and marketing activities. BMS also may use my information to combine it with other information BMS may collect about me and my CAMZYOS treatment and use it for the purposes described above. Use of my information will be governed by the BMS Privacy Policy. From time to time the Privacy Policy may change and I understand that I should check the website at www.bms.com for the most recent version. I can stop future marketing communications and use of my information by calling 1-855-226-9967.

Text Messages: By consenting below, I agree to receive autodialed text messages on behalf of Bristol Myers Squibb and to the Terms and Conditions of this Mobile Program ("Program") (visit <https://www.camzyos.com/?ovl=mobile>). [I will receive no more than 5 messages a month during the course of the program.] Consent is not a condition of purchase or use of any Bristol Myers Squibb product. The Program is valid with most major US carriers. If my mobile phone number changes in the future, I agree to promptly notify Bristol Myers Squibb. Message and data rates may apply. I can opt-out at any time by texting STOP to 32086. I will receive one final text confirming my opt-out request.

I CONSENT TO RECEIVE TEXTS.

I HAVE READ THIS AUTHORIZATION AND AGREE TO MYNURSE NAVIGATOR TERMS:

Patient Name:

Mobile Phone:

Date:

! SIGNATURE OF PATIENT

Only patients may provide authorization for the MyNurse Navigator Program; patient representative may not sign.

Additional Important Safety Information for CAMZYOS™ (mavacamten)

CONTRAINDICATIONS

CAMZYOS is contraindicated with concomitant use of:

- Moderate to strong CYP2C19 inhibitors or strong CYP3A4 inhibitors
- Moderate to strong CYP2C19 inducers or moderate to strong CYP3A4 inducers

WARNINGS AND PRECAUTIONS

Heart Failure

CAMZYOS reduces systolic contraction and can cause heart failure or totally block ventricular function. Patients who experience a serious intercurrent illness (e.g., serious infection) or arrhythmia (e.g., atrial fibrillation or other uncontrolled tachyarrhythmia) are at greater risk of developing systolic dysfunction and heart failure.

Assess the patient's clinical status and LVEF prior to and regularly during treatment and adjust the CAMZYOS dose accordingly. New or worsening arrhythmia, dyspnea, chest pain, fatigue, palpitations, leg edema, or elevations in N-terminal pro-B-type natriuretic peptide (NT-proBNP) may be signs and symptoms of heart failure and should also prompt an evaluation of cardiac function.

Asymptomatic LVEF reduction, intercurrent illnesses, and arrhythmias require additional dosing considerations.

(continued on next page)

Please see additional Important Safety Information throughout and **U.S. Full Prescribing Information**, including **Boxed WARNING** and **Medication Guide**.

Additional Important Safety Information for CAMZYOS® (mavacamten)

WARNINGS AND PRECAUTIONS (cont.)

Initiation of CAMZYOS in patients with LVEF <55% is not recommended. Avoid concomitant use of CAMZYOS in patients on disopyramide, ranolazine, verapamil with a beta blocker, or diltiazem with a beta blocker as these medications and combinations increase the risk of left ventricular systolic dysfunction and heart failure symptoms and clinical experience is limited.

CYP 450 Drug Interactions Leading to Heart Failure or Loss of Effectiveness

CAMZYOS is primarily metabolized by CYP2C19 and CYP3A4 enzymes. Concomitant use of CAMZYOS and drugs that interact with these enzymes may lead to life-threatening drug interactions such as heart failure or loss of effectiveness.

Advise patients of the potential for drug interactions, including with over-the-counter medications (such as omeprazole, esomeprazole, or cimetidine). Advise patients to inform their healthcare provider of all concomitant products prior to and during CAMZYOS treatment.

CAMZYOS Risk Evaluation and Mitigation Strategy (REMS) Program

CAMZYOS is only available through a restricted program called the CAMZYOS REMS Program because of the risk of heart failure due to systolic dysfunction. Notable requirements of the CAMZYOS REMS Program include the following:

- Prescribers must be certified by enrolling in the REMS Program.
- Patients must enroll in the REMS Program and comply with ongoing monitoring requirements.
- Pharmacies must be certified by enrolling in the REMS Program and must only dispense to patients who are authorized to receive CAMZYOS.
- Wholesalers and distributors must only distribute to certified pharmacies.

Further information is available at www.CAMZYOSREMS.com or by telephone at 1-833-628-7367.

Embryo-Fetal Toxicity

CAMZYOS may cause fetal toxicity when administered to a pregnant female, based on animal studies. Confirm absence of pregnancy in females of reproductive potential prior to treatment and advise patients to use effective contraception during treatment with CAMZYOS and for 4 months after the last dose. CHCs containing a combination of ethinyl estradiol and norethindrone may be used with CAMZYOS. However, CAMZYOS may reduce the effectiveness of certain other combined hormonal contraceptives (CHC). If these CHCs are used, advise patients to add nonhormonal contraception (such as condoms) during concomitant use and for 4 months after the last dose of CAMZYOS.

ADVERSE REACTIONS

In the EXPLORER-HCM trial, adverse reactions occurring in >5% of patients and more commonly in the CAMZYOS group than in the placebo group were dizziness (27% vs 18%) and syncope (6% vs 2%). There were no new adverse reactions identified in VALOR-HCM.

Effects on Systolic Function

In the EXPLORER-HCM trial, mean (SD) resting LVEF was 74% (6) at baseline in both treatment groups. Mean (SD) absolute change from baseline in LVEF was -4% (8) in the CAMZYOS group and 0% (7) in the placebo group over the 30-week treatment period. At Week 38, following an 8-week interruption of trial drug, mean LVEF was similar to baseline for both treatment groups. In the EXPLORER-HCM trial, 7 (6%) patients in the CAMZYOS group and 2 (2%) patients in the placebo group experienced reversible reductions in LVEF <50% (median 48%: range 35-49%) while on treatment. In all 7 patients treated with CAMZYOS, LVEF recovered following interruption of CAMZYOS.

DRUG INTERACTIONS

Potential for Other Drugs to Affect Plasma Concentrations of CAMZYOS

CAMZYOS is primarily metabolized by CYP2C19 and to a lesser extent by CYP3A4 and CYP2C9. Inducers and inhibitors of CYP2C19 and moderate to strong inhibitors or inducers of CYP3A4 may affect the exposures of CAMZYOS.

Impact of Other Drugs on CAMZYOS:

- Moderate to Strong CYP2C19 Inhibitors or Strong CYP3A4 Inhibitors: Concomitant use increases CAMZYOS exposure, which may increase the risk of heart failure due to systolic dysfunction. Concomitant use is contraindicated.

(continued on next page)

Please see additional Important Safety Information throughout and **U.S. Full Prescribing Information**, including **Boxed WARNING** and **Medication Guide**.

Additional Important Safety Information for CAMZYOS® (mavacamten) (cont.)

DRUG INTERACTIONS (cont.)

- **Moderate to Strong CYP2C19 Inducers or Moderate to Strong CYP3A4 Inducers:** Concomitant use decreases CAMZYOS exposure, which may reduce CAMZYOS' efficacy. The risk of heart failure due to systolic dysfunction may increase with discontinuation of these inducers as the levels of induced enzyme normalizes. Concomitant use is contraindicated.
- **Weak CYP2C19 Inhibitors or Moderate CYP3A4 Inhibitors:** Concomitant use with a weak CYP2C19 inhibitor or a moderate CYP3A4 inhibitor increases CAMZYOS exposure, which may increase the risk of adverse drug reactions. Initiate CAMZYOS at the recommended starting dose of 5 mg orally once daily in patients who are on stable therapy with a weak CYP2C19 inhibitor or a moderate CYP3A4 inhibitor. Reduce dose of CAMZYOS by one level (i.e., 15 to 10 mg, 10 to 5 mg, or 5 to 2.5 mg) in patients who are on CAMZYOS treatment and intend to initiate a weak CYP2C19 inhibitor or a moderate CYP3A4 inhibitor. Schedule clinical and echocardiographic assessment 4 weeks after inhibitor initiation, and do not up-titrate CAMZYOS until 12 weeks after inhibitor initiation. Avoid initiation of concomitant weak CYP2C19 and moderate CYP3A4 inhibitors in patients who are on stable treatment with 2.5 mg of CAMZYOS because a lower dose is not available.

Potential for CAMZYOS to Affect Plasma Concentrations of Other Drugs

CAMZYOS is an inducer of CYP3A4, CYP2C9, and CYP2C19. Concomitant use with CYP3A4, CYP2C9, or CYP2C19 substrates may reduce plasma concentration of these drugs. Closely monitor when CAMZYOS is used with concomitant CYP3A4, CYP2C9, or CYP2C19 substrates unless otherwise recommended in the Prescribing Information.

Certain Combined Hormonal Contraceptives (CHC): Progestin and ethinyl estradiol are CYP3A4 substrates. Concomitant use of CAMZYOS may decrease exposures of certain progestins, which may lead to contraceptive failure. CHCs containing a combination of ethinyl estradiol and norethindrone may be used with CAMZYOS, but if other CHCs are used, advise patients to add nonhormonal contraception (such as condoms) during concomitant use and 4 months after the last dose of CAMZYOS.

Drugs That Reduce Cardiac Contractility

Expect additive negative inotropic effects of CAMZYOS and other drugs that reduce cardiac contractility. Avoid concomitant use of CAMZYOS in patients on disopyramide, ranolazine, verapamil with a beta blocker, or diltiazem with a beta blocker as these medications and combinations increase the risk of left ventricular systolic dysfunction and heart failure symptoms and clinical experience is limited.

If concomitant therapy with a negative inotrope is initiated, or if the dose of a negative inotrope is increased, monitor LVEF closely until stable doses and clinical response have been achieved.

SPECIFIC POPULATIONS

Pregnancy

CAMZYOS may cause fetal harm when administered to a pregnant female. Advise pregnant females about the potential risk to the fetus with maternal exposure to CAMZYOS during pregnancy. There is a pregnancy safety study for CAMZYOS. If CAMZYOS is administered during pregnancy, or if a patient becomes pregnant while receiving CAMZYOS or within 4 months after the last dose of CAMZYOS, healthcare providers should report CAMZYOS exposure by contacting Bristol Myers Squibb at 1-800-721-5072 or www.bms.com.

Lactation

The presence of CAMZYOS in human or animal milk, the drug's effects on the breastfed infant, or the effects on milk production are unknown. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for CAMZYOS and any potential adverse effects on the breastfed child from CAMZYOS or from the underlying maternal condition.

Females and Males of Reproductive Potential

Confirm absence of pregnancy in females of reproductive potential prior to initiation of CAMZYOS. Advise females of reproductive potential to use effective contraception during treatment with CAMZYOS and for 4 months after the last dose. CHCs containing a combination of ethinyl estradiol and norethindrone may be used with CAMZYOS. However, CAMZYOS may reduce the effectiveness of certain other combined hormonal contraceptives (CHC). If these CHCs are used, advise patients to add nonhormonal contraception (such as condoms) during concomitant use and for 4 months after the last dose of CAMZYOS.

Please see additional Important Safety Information throughout and **U.S. Full Prescribing Information**, including **Boxed WARNING** and **Medication Guide**.

To receive co-pay assistance or free medication from BMS, patients must comply with the Program rules, and patients may not be reimbursed for the assistance they received from anyone else, including from an insurance program; another charity; or from a health savings, flexible spending, or other health reimbursement account. Assistance may be temporary, and patients may be required to apply every year. Patients must contact the Program at 1-855-226-9967 if their insurance or treatment changes in any way. Medicare Part D patients may not count any free medication received toward their true out-of-pocket (TrOOP) costs.

Echocardiogram Co-Pay Assistance Program Terms & Conditions

Eligibility Requirements

- Patients must have commercial (private) insurance and must be treated with CAMZYOS for an on-label indication
- Patients must be 18 years of age or older
- Patients must live in the United States or United States territories
- Patients are not eligible if they have medical insurance coverage through a state or federal healthcare program, including but not limited to Medicare, Medicaid, MediGap, CHAMPUS, TRICARE, Veterans Affairs (VA), or Department of Defense (DoD) programs; patients who move from commercial plans to state or federal healthcare programs will no longer be eligible
- Patients residing in Massachusetts, Minnesota, or Rhode Island are not eligible

Program Benefits

- The Program includes a medical benefit offer for reimbursement of patient's out-of-pocket costs for required echocardiogram procedures where the full cost is not covered by the patient's insurance; program does not reimburse for other associated costs such as supplies, office visits or physician related services including interpretation of echocardiograms
- Patients may pay as little as \$0 in out-of-pocket costs per echocardiogram procedure, subject to an annual maximum benefit of \$2,500. Patients are responsible for any costs that exceed the maximum benefit
- To receive the Program benefits, a claim must be submitted within 180 days from the date of the Explanation of Benefits (EOB)
- The program may apply retroactively to out-of-pocket costs for echocardiograms that occurred within 180 days prior to the date of enrollment
- All Program payments are for the benefit of the patient only

Program Timing

- Patients will be evaluated for ongoing eligibility and will continue enrollment in the program if all eligibility requirements are met

Additional Terms & Conditions

- Patients and prescribers may not seek reimbursement from health insurance, health savings, or flexible spending accounts, or any third party, for any part of the benefit received by the patient through this offer
- Acceptance of this offer confirms that this offer is consistent with patient's insurance. Patients and healthcare providers must report the receipt of co-pay assistance benefits if required by patient's insurance provider
- Offer valid only in the United States and United States Territories. Void where prohibited by law, taxed, or restricted
- The Program is not insurance, not transferable and not conditioned on any past, present, or future purchase
- No membership fees
- Bristol Myers Squibb reserves the right to rescind, revoke, or amend this offer at any time without notice

Bridge Program Terms & Conditions

Eligibility Requirements

- Patients must have commercial (private) insurance and must be treated with CAMZYOS for an on-label indication
- Patients must be 18 years of age or older
- Patients must live in the United States or United States territories
- Patients are not eligible if they have medical insurance coverage through a state or federal healthcare program, including but not limited to Medicare, Medicaid, MediGap, CHAMPUS, TRICARE, Veterans Affairs (VA), or Department of Defense (DoD) programs; patients who move from commercial plans to state or federal healthcare programs will no longer be eligible

Program Benefits

- If a coverage determination is delayed for twenty (20) calendar days or more, the patient will be provided CAMZYOS at no cost until coverage is received, a prior authorization is denied and not appealed, or for 18 dispenses, whichever is earlier

Program Timing

- Patients will be evaluated for ongoing eligibility and may not exceed 18 dispenses

Additional Terms & Conditions

- An appeal of any prior authorization denial must be made within 60 days of prior authorization denial date or as per payer guidelines to remain in the Program
- Patients continuing into the following year will be re-verified for eligibility in January. A new prior authorization may be required and must be submitted within 30 days for patients to continue in the Program.
- Program reserves the right to re-verify patient's insurance coverage at any point during the patient's participation in the Program
- No claim for reimbursement for product dispensed pursuant to this offer may be made to any third-party payer
- Valid only in the United States and United States territories
- Other restrictions may apply
- The Program is not insurance, not transferable and not conditioned on any past, present, or future purchase
- Bristol Myers Squibb reserves the right to modify or discontinue this offer at any time without notice

Free 35-Day Trial Offer Program Terms & Conditions

Eligibility Requirements

- Patients must not have previously filled a prescription for CAMZYOS
- Patient must have a valid 35-day, 5 milligram prescription for CAMZYOS for an on-label indication
- Patients are 18 years of age or older
- Patients must live in the United States or a US Territory

Program Benefits

- Eligible patients with a valid 35-day prescription for CAMZYOS can receive a free 35-day supply of CAMZYOS. Patient is responsible for applicable taxes, if any. This offer may not be redeemed on prescriptions written for longer than 35 days
- This offer is limited to one use per patient per lifetime and is nontransferable. By redeeming this offer, the patient certifies that they have not previously filled a prescription for CAMZYOS
- The Free 35-Day Trial for the specified prescription cannot be combined with any other rebate/coupon, free trial or similar offer. No substitutions are permitted.

Additional Terms and Conditions

- Patients, pharmacists, and prescribers cannot seek reimbursement for the Free 35-Day Trial of CAMZYOS from health insurance or any third party, including state or federally funded programs.
- Patients may not count the Free 35-Day Trial of CAMZYOS as an expense incurred for purposes of determining out-of-pocket costs for any plan, including true out-of-pocket costs (TrOOP), for purposes of calculating the out-of-pocket threshold for Medicare Part D plans.
- Only valid in the United States and US Territories; this offer is void where restricted or prohibited by law.
- The Program is not insurance, not transferable and not conditioned on any past, present, or future purchase
- Bristol Myers Squibb reserves the right to rescind, revoke or amend this offer at any time without notice.

Pharmacy Co-Pay Assistance Program Terms & Conditions

Eligibility Requirements

- Patients must have commercial (private) insurance, but their coverage does not cover the full cost of the prescription. Co-pay assistance is not valid where the entire cost of the prescription is reimbursed by insurance
- Patients must be 18 years of age or older
- Patients must live in the United States or United States territories
- Patients are not eligible if they have prescription insurance coverage through a state or federal healthcare program, including but not limited to Medicare, Medicaid, MediGap, CHAMPUS, TRICARE, Veterans Affairs (VA), or Department of Defense (DoD) programs; patients who move from commercial to state or federal healthcare program insurance will no longer be eligible
- Cash-paying patients are not eligible for co-pay assistance

Program Benefits

- Eligible patients with an activated co-pay offer and a valid prescription may pay as little as \$10 per 30-day supply; monthly, annual, and/or per-claim maximum program benefits may apply and vary from patient to patient, depending on the terms of a patient's prescription drug plan and to ensure that the funds are used for the benefit of the patient, based on factors determined solely by Bristol Myers Squibb.
- Some prescription drug plans have established programs referred to as "co-pay maximizer" programs. A co-pay maximizer program is one in which the amount of the patient's out-of-pocket costs is adjusted to reflect the availability of support offered by a co-pay support program. Patients enrolled in co-pay maximizer programs may receive program benefits that vary over time to ensure the program funds are used for the benefit of the patient.

Program Timing

- Patients will be evaluated for ongoing eligibility to continue enrollment in the program. In the event patients experience a change in insurance coverage or BMS makes changes to the copay assistance program, patients may be required to re-enroll into the program and provide updated insurance information to determine eligibility.

Additional Terms & Conditions

- Patients, pharmacists, and prescribers may not seek reimbursement from health insurance, health savings or flexible spending accounts, or any third party for any part of the benefit received by the patient through this offer
- Acceptance of this offer confirms that this offer is consistent with patient's insurance. Patients, pharmacists, and healthcare providers must report the receipt of co-pay assistance benefits if required by patient's insurance provider
- All Program payments are for the benefit of the patient only
- Offer valid only in the United States and United States Territories. Void where prohibited by law, taxed, or restricted
- The Program is limited to one per patient. This offer cannot be combined with any other offer, rebate, coupon, or free trial
- This Program is not insurance, not transferrable and not conditioned on any past, present, or future purchase, including refills
- No membership fees
- Bristol Myers Squibb reserves the right to rescind, revoke, or amend this offer at any time without notice

Please see additional Important Safety Information throughout and **U.S. Full Prescribing Information**, including **Boxed WARNING** and **Medication Guide**.