MYQORZO™ REMS

Healthcare Provider Enrollment Form

MYQORZO™ (aficamten) 5·10·15·20 mg tablets

Instructions:

1. Review the Prescribing Information, **REMS Overview**, and the **Education Program for Healthcare Providers and Pharmacies**.
2. Successfully complete the **Healthcare Provider Knowledge Assessment** by receiving a passing score of 100% and submit to the REMS.
3. Enroll by completing and submitting the **Healthcare Provider Enrollment Form** to the REMS:
   - Online at **www.MYQORZOREMS.com**, or
   - By fax to 1-844-285-7399

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 2 business days.

Healthcare Provider Information (Fields marked * are REQUIRED)

*First Name:	Middle Initial:	*Last Name:

*Credentials: ☐ MD ☐ DO ☐ PA ☐ NP ☐ Other (please specify):

*Specialty: ☐ Cardiology ☐ Internal/General Medicine ☐ Other (please specify):

*Healthcare Provider NPI #:

*Practice/Facility Name:

*Address:

*City:	*State:	*ZIP Code:

*Phone Number: Area Code/Telephone Number	*Fax Number: Area Code/Fax Number

*Email:

*Preferred Method of Contact (please specify): ☐ Email ☐ Phone ☐ Fax	Preferred Time of Contact: ☐ AM ☐ PM

REMS Support Staff Information (Optional): Healthcare providers may grant administrative rights to up to four REMS support staff per affiliated healthcare setting. REMS support staff may fill out **Patient Enrollment Forms** and/or **Patient Monitoring Forms** on behalf of the certified healthcare provider online or by hard copy. The certified healthcare provider of record is responsible for reviewing, signing, and submitting these forms to the REMS.

I, the healthcare provider, grant administrative rights to the REMS support staff listed below, affiliated with the healthcare setting named above, and understand that I must review all paperwork prior to submitting to the REMS.

First Name:	Last Name:
Phone Number:	Email:
First Name:	Last Name:
Phone Number:	Email:
First Name:	Last Name:
Phone Number:	Email:
First Name:	Last Name:
Phone Number:	Email:

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Healthcare Provider Agreement

By completing, signing, and submitting this form, I agree and acknowledge that:

To become certified, I must:

- Review the drug's Prescribing Information, **REMS Overview**, and the **Education Program for Healthcare Providers and Pharmacies**.
- Successfully complete the **Healthcare Provider Knowledge Assessment** and submit it to the REMS.
- Enroll by completing and submitting the **Healthcare Provider Enrollment Form** to the REMS.

Before treatment initiation (first dose), I must:

- Counsel the patient on the risk of heart failure due to systolic dysfunction using the **Patient Guide**. Provide a copy of the material to the patient.
- Assess the patient's cardiovascular status and the appropriateness of initiating treatment by obtaining an echocardiogram. Document and submit confirmation of an echocardiogram and authorization for treatment to the REMS using the **Patient Enrollment Form**.
- Enroll the patient by completing and submitting the **Patient Enrollment Form** to the REMS.

During treatment: 2 to 8 weeks after treatment initiation and each dose change, then every 3 or 6 months thereafter (depending on echocardiogram results), I must:

- Counsel the patient on the risk of heart failure due to systolic dysfunction using the **Patient Guide**.
- Assess the patient's cardiovascular status and the appropriateness of continuing treatment by obtaining an echocardiogram.
- Document and submit confirmation of review of the patient's echocardiogram results and authorization for treatment to the REMS using the **Patient Monitoring Form**.

At all times, I must:

- Report adverse events of heart failure due to systolic dysfunction to Cytokinetics, Inc.

Provide Signature Below

By signing below, I acknowledge the above agreements and my obligations as a MYQORZO healthcare provider to comply with MYQORZO REMS requirements, and I understand my personally identifiable information provided above will be shared with Cytokinetics, Inc., its agents, contractors, and affiliates and entered into a healthcare provider database for the MYQORZO REMS. I agree that I may be contacted in the future by mail, email, fax, and/or phone concerning MYQORZO, the MYQORZO REMS, and other MYQORZO programs and services.

*Healthcare Provider Signature:	*Date (MM/DD/YYYY):

Note: MYQORZO REMS certified healthcare providers may add additional practices/facilities and or REMS support staff either through the MYQORZO REMS Website or by contacting the MYQORZO REMS Call Center.

If you have any questions about the MYQORZO REMS, please call the MYQORZO REMS Call Center at 1-844-285-7367. For MYQORZO REMS Call Center hours, visit www.MYQORZOREMS.com.

PHONE: 1-844-285-7367 FAX: 1-844-285-7399 www.MYQORZOREMS.com

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