Patient Authorization and Agreement Form

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 & 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 2.
- 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 Caretakers to accept payment from BMS in exchange for providing my information as well as providing me with marketing and patient support services.

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*Required Field

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 52160

PHOENIX AZ 85072-2160

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:

Print Name of Patient or Patient Representative*: ◎ Check here if you are a Patient Representative

Representative's Relationship to Patient*: Preferred Email:

SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE* 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.

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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.

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:

SIGNATURE OF PATIENT Date:

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

Click here for U.S. Full Prescribing Information, including **Boxed WARNINGS** and Medication Guide, or visit MyCAMZYOS.com.