MYQORZO & You Start Form

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

PHONE: 833-MYQORZO (833-697-6796)
FAX: 833-697-6799
ONLINE: hcp.iassist.com

MYQORZO & You™ PERSONALIZED PATIENT SUPPORT

FOR YOUR OFFICE: Submit via online portal or fax completed form to 833-697-6799, including all items with red asterisks, prescriber attestation, and patient signature.

FOR YOUR PATIENTS: Complete the patient sections as designated on the form, including Patient Authorization and Agreement.

GET READY: A dedicated MYQORZO Navigator will call your patient from 833-MYQORZO (833-697-6796) within 1 business day.

**Indicates required fields to process form, including patient signature.*

1 PATIENT INFORMATION

Preferred Method of Contact: ☐ Phone ☐ Email ☐ Text: By checking "Text," you consent to receive text messages

*First Name: _____ MI: _____ *Last Name: _____ Sex: ☐ M ☐ F

Is this a MYQORZO™ clinical trial patient? ☐ Yes ☐ No *DOB (mm/dd/yyyy): _____

*Email: _____ *Preferred Phone Number: _____

*Street Address: _____ *City: _____ *State: _____ *ZIP Code: _____

Language translation needed? ☐ Yes ☐ No If yes, please indicate language: _____

AUTHORIZED CONTACT (Optional): Authorized Contact Name: _____

Relationship to Patient: _____ Phone Number: _____ Email: _____

I HAVE READ AND AGREE TO THE PATIENT AUTHORIZATION ON PAGE 2: I am a (check one): ☐ Patient ☐ Authorized Representative

*Print Name: _____ *Signature: _____ *Date (mm/dd/yyyy): _____

2 INSURANCE INFORMATION

Please include copies of the front and back of all insurance cards. | ☐ **Check here if patient does not have insurance**

***Primary Insurance Provider:** _____ *Policy ID #: _____ Group #: _____

Policyholder Name (First, MI, Last), if not the patient: _____

Relationship to patient: _____ Policyholder DOB (mm/dd/yyyy): _____ Insurance Phone: _____

***Primary Pharmacy Plan Provider:** _____ *Policy ID #: _____ *Group #: _____

*Rx BIN #: _____ Rx PCN #: _____ Insurance Phone: _____

Policyholder Name (First, MI, Last), if not the patient: _____ Policyholder DOB (mm/dd/yyyy): _____

3 PRESCRIBER INFORMATION

*Prescriber Name (First, Last): _____ *Facility Name: _____

Specialty: _____ *NPI #: _____ State License #: _____ Tax ID #: _____

*Facility Street Address: _____ *City: _____ *State: _____ *ZIP Code: _____

*Facility Phone: _____ *Facility Fax: _____ *Staff Contact Name (First, Last): _____

*Staff Contact Phone: _____ *Staff Contact Email: _____

4 PRESCRIPTION INFORMATION: MYQORZO™ (aficamten)

Rx dosage will be verified. New Rx may be required.

Only healthcare providers certified in the MYQORZO Risk Evaluation and Mitigation Strategy (REMS) Program are authorized to prescribe MYQORZO.

***ICD-10* Diagnosis Code:** ☐ I42.1 Obstructive Hypertrophic Cardiomyopathy

☐ MYQORZO & You Free Trial Offer Rx For eligible, government-insured patients	MYQORZO & You Bridge Program Rx For eligible, commercially insured patients	Patient Assistance Program Rx (pending eligibility)
5 mg, PO QD, QTY: 30	☐ 5 mg ☐ 10 mg ☐ 15 mg ☐ 20 mg PO QD, QTY: 30 Refill(s) _____	☐ 5 mg ☐ 10 mg ☐ 15 mg ☐ 20 mg PO QD, QTY: 30 Refill(s) _____

For Free Product dose adjustments, please submit the new prescription to AssistRx Specialty Pharmacy (NPI 1528306297) via eScript or fax to 866-930-4147.

Select a MYQORZO Specialty Pharmacy for when an Rx is triaged:

☐ CareMed ☐ Orsini HC ☐ Integrated Delivery Network: _____

MYQORZO Rx for Specialty Pharmacy ☐ 5 mg ☐ 10 mg ☐ 15 mg ☐ 20 mg | PO QD, QTY: 30 Refill(s) _____

I HAVE READ AND AGREE TO THE PRESCRIBER ATTESTATION ON PAGE 2: ☐ Dispense as Written

*Signature: _____ *Date (mm/dd/yyyy): _____

5 ECHOCARDIOGRAM BENEFITS INVESTIGATION

Echocardiogram Procedure Code required for Medical Benefits Investigation.

If eligible, all commercially insured patients will be enrolled in the MYQORZO & You copay assistance programs.

*CPT Code: ☐ 93306 ☐ 93307 ☐ 93308 ☐ 93320 ☐ 93325 ☐ 93350 ☐ 93351 ☐ Other _____

If the echocardiogram will be performed at a site different than the practice in section 3, please include:

Facility Name: _____ NPI #: _____ Tax ID #: _____

Tax ID # is required for Medical (echocardiogram) Benefits Investigation for Medicare patients.

INDICATIONS AND USAGE

MYQORZO is indicated for the treatment of adults with symptomatic obstructive hypertrophic cardiomyopathy (oHCM) to improve functional capacity and symptoms.

Please see Important Safety Information on page 3 and full Prescribing Information, including Boxed WARNING, and Medication Guide.

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6 PRESCRIBER ATTESTATION AND PATIENT AUTHORIZATION AND AGREEMENT

My signature below certifies that the person named on this form is my patient; the information provided on this application, to the best of my knowledge, is complete and accurate; therapy with the product prescribed is medically necessary; and I will be supervising the patient's treatment. I have obtained from my patient his or her consent and any required written authorization as required by HIPAA and other federal or state laws to release to Cytokinetics Inc and its representatives/agents all patient information needed for processing this application, including, without limitation, my patient's financial and medical information. I understand that my patient's information provided to Cytokinetics Inc and its representatives/agents is solely to verify my patient's insurance coverage; to assess, if applicable, my patient's eligibility for MYQORZO & You financial assistance programs; and to dispense the medication. I understand that information I provide on this form, if signed by the patient, will be used by Cytokinetics Inc and its representatives/agents as authorized by the patient. I authorize MYQORZO & You to act on my behalf for the limited purposes of transmitting this prescription to the dispensing pharmacy. I understand that free product is not contingent on any purchase obligations. I further acknowledge that no medication received free of charge under the Program shall be offered for sale, trade, or barter, and that no claim for reimbursement of either MYQORZO™ or related medical procedures and services will be submitted to Medicare, Medicaid, or any third-party payer in connection with MYQORZO provided for free under the MYQORZO & You Patient Support Program.

I certify, if the patient is enrolled in the MYQORZO & You Copay Savings Program, to the following:

- I have read and will comply with the Program Terms and Conditions on page 4
- 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 and acknowledge that Cytokinetics Inc and MYQORZO & You may revise, change, or terminate any Program services at any time without notice to me. My information will be processed as set forth in the Cytokinetics Inc Privacy Policy at http://www.cytokinetics.com/privacy-policy/

I authorize my healthcare providers and staff, my health insurer, health plan, or programs that provide healthcare benefits for me (together, "Health Insurers"), and any dispensing pharmacies that dispense my medication to disclose to Cytokinetics Inc and its representatives/agents relevant health information about me, including information related to my medical condition and treatment, medical records, health insurance coverage, claims, prescription fill/refill information, financial information, and contact information (together, "My Information"), for the purposes of providing the Program services, including:

- To use the information I provided on the MYQORZO & You Patient Support Program Start Form to determine if I am eligible for the echocardiogram copay assistance, free medication, bridge or patient assistance program and to assist in my enrollment and continued participation in these programs
- To investigate my health insurance coverage for Cytokinetics Inc medications that I have been prescribed through benefits verification, prior authorization, and/or appeals determination support
- To coordinate my treatment with MYQORZO with my healthcare providers and pharmacy
- To communicate with me by mail, email, text message, telephone, or other means about my medical condition, treatment, health insurance, and participation in the MYQORZO & You Patient Support Program (for example, contact me for missing information or for fulfillment of product)
- To conduct other activities, as appropriate, to administer the MYQORZO & You Patient Support Program

I understand and agree that:

- My healthcare providers, Health Insurers, and specialty pharmacy(s) may receive remuneration from Cytokinetics Inc in exchange for disclosing My Information to Cytokinetics Inc and/or for providing me with support services for Cytokinetics Inc medications
- Once My Information has been disclosed to Cytokinetics Inc, I understand that federal privacy laws may no longer protect it from further disclosure. However, Cytokinetics Inc agrees to protect My Information by using and disclosing it only for the purposes allowed by me in this Authorization or as otherwise required by law
- I do not have to sign this Authorization to receive my medication and that I may revoke it at any time, but if I refuse to sign or revoke my authorization, I will not be able to receive assistance from any MYQORZO & You patient support programs
- A decision by me to not sign or to revoke this Authorization will not affect my ability to obtain medical treatment, insurance coverage, access to health benefits, or Cytokinetics Inc medications outside of the Program

I understand that I may withdraw (take back) this Authorization at any time, or request removal of any of My Information that was previously disclosed to Cytokinetics Inc, by mailing or faxing a written request to Cytokinetics Inc at MYQORZO & You Patient Support Program, PO Box 7613 Overland Park, KS, 66207. I understand this authorization will remain in effect for a period of five (5) years or until I withdraw (take back).

Patient Certification:

I understand that completing the MYQORZO & You Patient Support Program Start Form is not a guarantee of eligibility for any of the MYQORZO & You patient support programs. I also understand that Cytokinetics Inc may change or discontinue the MYQORZO & You patient support programs at any time without notice, except that if I am enrolled in a Medicare Part D plan, my benefits will continue until the end of the calendar year. I understand that if I am currently enrolled in a Medicare Part D plan, I cannot utilize my Part D plan benefits for products received through the MYQORZO & You patient support programs for the duration of my enrollment in these programs. I understand that free product is not contingent on any purchase obligations. Any free medication or benefits I receive through the MYQORZO & You Patient Support Program will not count toward my true-out-of-pocket (TrOOP) expenses in Medicare Part D. The MYQORZO & You Patient Support Program will communicate with my Medicare Part D plan to notify them of the assistance I am receiving. I also certify that:

- The information I provided on the MYQORZO & You Patient Support Program Start Form is complete and accurate
- I will not request reimbursement from any insurance carrier or government health benefit program for Cytokinetics Inc products that I receive from the Program
- I will notify the MYQORZO & You Patient Support Program within thirty (30) days if my financial status or health insurance coverage changes
- If I decide to enroll or have been "auto-enrolled" in a Medicare Part D plan, I will inform the MYQORZO & You Patient Support Program immediately at 833-MYQORZO (833-697-6796)
- I am over 18 years old*
- I understand that the information I have provided will be used only by Cytokinetics and its contracted third parties to contact me via email with information related to the patient support program. Cytokinetics will not sell or transfer my name or contact information to any third parties for their marketing use. In the event that I wish to opt out of receiving email communications for the patient support program, I can click on the "unsubscribe" link at the bottom of the email communications to be removed within 10 business days.

Cytokinetics respects your privacy and we will not sell or share your personal information. If you are a California resident, and to view our Privacy Policy including contact preferences, please visit: www.cytokinetics.com/privacy-policy/

Permission for Text Communications:

I understand that by providing my consent to receive text messages from MYQORZO & You, I agree to receive text messages related to ongoing support. Message and data rates apply. Message frequency varies. I understand I am not required to provide my permission to receive text messages to participate in MYQORZO & You.

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IMPORTANT SAFETY INFORMATION

WARNING: RISK OF HEART FAILURE

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

Echocardiogram assessments are required prior to and during treatment with MYQORZO to monitor for systolic dysfunction. Initiation of MYQORZO in patients with LVEF <55% is not recommended. Decrease the dose of MYQORZO if LVEF is <50% and ≥40%. Interrupt the dose of MYQORZO if LVEF <40% or if the patient experiences heart failure symptoms or worsening clinical status due to systolic dysfunction.

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

CONTRAINDICATIONS

MYQORZO is contraindicated with concomitant use of rifampin.

WARNING AND PRECAUTIONS

Heart Failure

MYQORZO reduces cardiac contractility, which can reduce LVEF and cause heart failure.

Patients who experience a serious intercurrent illness (eg, serious infection) or arrhythmia (eg, new or uncontrolled atrial fibrillation) may be at greater risk of developing systolic dysfunction and heart failure.

Assess patients' clinical status and LVEF prior to and during treatment and adjust the MYQORZO dose accordingly. New or worsening arrhythmia, dyspnea, chest pain, fatigue, leg edema, or elevations in N-terminal pro-B-type natriuretic peptide may be signs and symptoms of heart failure.

Initiation of MYQORZO in patients with LVEF <55% is not recommended.

MYQORZO REMS Program

MYQORZO is available only through a restricted program called the MYQORZO REMS Program, because of the risk of heart failure due to systolic dysfunction.

Notable requirements of the MYQORZO REMS Program include:

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

Further information is available at www.MYQORZOREMS.com, or at 1-844-285-7367.

Cytochrome P450 Interactions Leading to Heart Failure or Loss of Effectiveness

MYQORZO is metabolized primarily by CYP2C9, and to a lesser extent by CYP3A, CYP2D6, and CYP2C19 enzymes. Initiation of medications that inhibit multiple P450 pathways of MYQORZO elimination (eg, fluconazole, voriconazole, or fluvoxamine) or strong CYP2C9 inhibitors, and discontinuation of moderate-to-strong CYP3A inducers may lead to increased blood concentrations of aficamten and increase the risk of heart failure due to systolic dysfunction. Conversely, initiation of medications that induce P450 pathways of MYQORZO (eg, rifampin, moderate-to-strong CYP3A inducers) may lead to decreased blood concentrations of aficamten and potential loss of effectiveness. Assess LVEF 2 to 8 weeks after initiation of such inhibitors or after discontinuation of such inducers and adjust the dose of MYQORZO accordingly.

Advise patients of the potential for drug interactions. Advise patients to inform their healthcare provider of all concomitant medications prior to and during MYQORZO treatment.

ADVERSE REACTIONS

Hypertension (8% vs 2%) was the only adverse reaction occurring in >5% of patients and more commonly on MYQORZO than on placebo in the pivotal trial.

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TERMS AND CONDITIONS

MYQORZO & You Patient Support Program Terms and Conditions

By enrolling in the MYQORZO & You Patient Support Program ("Program"), the patient acknowledges that they currently meet the eligibility criteria and will comply with the following terms and conditions:

MYQORZO & You Free Trial Offer

The MYQORZO & You Free Trial Offer ("Program") provides eligible government-insured patients with a one-month supply of MYQORZO™ (aficamten) at no cost to initiate therapy and, in consultation with their healthcare provider, determine whether continued treatment is appropriate. Patients must have active government insurance coverage (excluding Department of Defense, Veterans Affairs, and TRICARE), reside in the United States, Washington, DC, or Puerto Rico, have a valid prescription for MYQORZO with an FDA-approved indication, have never received MYQORZO or participated in the Program, and complete a valid consent and signed start form with the MYQORZO & You Patient Support Program. Product is dispensed only through a Cytokinetics, Incorporated designated pharmacy, shipped to a valid U.S. or Puerto Rico residential address (no P.O. boxes), and limited to a lifetime one-month supply. No sale, trade, barter, export, distribution, or reimbursement from any insurer, government program, or third party is permitted, and the value may not be applied toward patient cost-sharing obligations, including Medicare Part D TrOOP expenses. For Medicare Part D beneficiaries, the applicable plan will be notified that the product is provided at no cost outside of the Part D benefit.

MYQORZO & You Copay Savings Program

The MYQORZO & You Copay Savings Program ("Program") provides financial assistance to eligible commercially insured patients to reduce out-of-pocket costs for MYQORZO and certain required echocardiograms. Eligible patients may pay as little as $5 per month for MYQORZO and as little as $0 for eligible echocardiogram reimbursement (limited to out-of-pocket costs not covered by insurance). Patients must have active commercial prescription insurance, be prescribed MYQORZO for an FDA-approved indication, be at least 18 years old, reside in the United States or Puerto Rico, and be enrolled in the MYQORZO & You Copay Savings Program with valid consent. The Program is not valid for prescriptions reimbursed, in whole or in part, by any federal or state healthcare program (including Medicare, Medicaid, Medigap, Department of Defense (DoD), Veterans Affairs (VA), TRICARE, Puerto Rico Government Insurance, or any state pharmaceutical assistance programs) and is unavailable to residents of Massachusetts, Minnesota, or Rhode Island. Patients who move from commercial insurance to federal or state health insurance will no longer be eligible and agree to notify the Program of any such change. Enrollment may be renewed for up to 12 months if eligibility is maintained. Patients agree not to seek reimbursement from any health insurance or third party for all or any part of the benefit received through the Program. This offer is not conditioned on any past, present, or future purchase or prescription of MYQORZO. Insurance entities may implement "accumulator" or "maximizer" programs, which restrict the application of manufacturer assistance toward a patient's deductible or other cost-sharing obligations. The value of this program is intended exclusively to benefit patients by applying toward eligible out-of-pocket obligations, including co-payments, coinsurance, and deductibles. The Program uses advanced logic to identify whether a claim for an enrolled patient is subject to an "accumulator" or "maximizer" program. The use of "accumulator" or "maximizer" programs by insurance entities limit the program benefits. These limits can be modified without prior notice. Use of the program for any purpose related to "accumulator" or "maximizer" programs constitutes a violation of these Terms and Conditions. Cytokinetics, Incorporated reserves the right to audit program activity, investigate suspected violations, and modify or terminate the program, including these Terms and Conditions, at any time without prior notice.

MYQORZO & You Bridge Program

The MYQORZO & You Bridge Program ("Program") provides, at no cost, up to a twelve (12) month supply of MYQORZO to eligible commercially insured patients for whom insurance coverage is being pursued but remains subject to delay. Patients must reside in the United States or Puerto Rico, have a valid prescription for MYQORZO with an FDA-approved indication, be enrolled in the MYQORZO & You Patient Support Program with valid consent and a signed start form, and not be enrolled in, eligible for, or receiving benefits from any federal or state healthcare program, including but not limited to Medicare (Part A, B, C, or D), Medicaid, Medigap, the Department of Defense (DoD) health programs, Veterans Affairs (VA) health programs, TRICARE, Puerto Rico Government Health Insurance, or any other similar federal or state patient or pharmaceutical assistance program, unless otherwise expressly permitted by applicable law. Product is dispensed only through Cytokinetics, Incorporated designated pharmacies, shipped to valid residential addresses (no P.O. boxes), and limited to quantities needed to bridge therapy until coverage is obtained or the Program ends. Enrollment is limited to one per qualifying event unless otherwise approved.

MYQORZO & You Patient Assistance Program (PAP)

The MYQORZO & You Patient Assistance Program (PAP) ("Program") provides MYQORZO at no cost to eligible patients meeting financial criteria who have no insurance coverage, have been denied coverage with no available appeal options or cannot afford their medication. Patients must be prescribed MYQORZO for an FDA-approved indication, reside in the United States or Puerto Rico, meet financial eligibility criteria and have no insurance or inadequate coverage for MYQORZO. Enrollment requires a completed start form with prescriber certification and patient attestation, and proof of income and insurance status may be required. Enrollment is valid for up to 12 months, or until the patient obtains insurance coverage, whichever occurs first, for commercially insured, underinsured, and uninsured patients. For government-insured patients, enrollment is valid through the end of the calendar year, unless otherwise restricted by applicable laws, regulations, or program terms and conditions. Continued participation in the Program beyond one year requires eligibility reassessment and re-enrollment. Patients may be required to re-verify insurance coverage status at any time during the Program. Program benefits are personal, non-transferable, and may not be sold, traded, or distributed. The Program does not guarantee continuous supply, and for Medicare Part D beneficiaries, the applicable plan will be notified that the product is provided at no cost outside of the Part D benefit, with no value applied toward TrOOP expenses.

General Terms & Conditions

All MYQORZO & You Patient Support Programs are intended for patients prescribed MYQORZO for an FDA-approved indication and are void where prohibited, restricted, or taxed by law. None of the programs constitute health insurance, a discount, rebate, coupon, or cost-sharing program. Participation is not conditioned on any past, present, or future purchase of MYQORZO or any other Cytokinetics, Incorporated product. Program benefits are personal to the enrolled patient, non-transferable, and may not be sold, purchased, traded, bartered, exported, or distributed. No party may seek reimbursement, credit, or other compensation from any insurer, government healthcare program, or third-party payer for products or services provided under these programs, unless otherwise permitted by law. No membership fees for the Program. Cytokinetics, Incorporated reserves the right, in its sole discretion, to interpret, modify, suspend, or terminate any program or its eligibility criteria at any time without prior notice. Certain other rules and restrictions may apply. Participation in any MYQORZO & You program constitutes agreement to the applicable program Terms and Conditions and authorization for the use of personal health and, if applicable, personally identifiable and financial information solely for program administration in accordance with applicable laws and the Cytokinetics, Incorporated Privacy Policy https://cytokinetics.com/privacy-policy/. If you are a resident of California or certain other states (Colorado, Connecticut, Delaware, Florida, Iowa, Nebraska, New Hampshire, New Jersey), please see our Privacy Policy for privacy rights that may apply to you or contact privacy@cytokinetics.com.

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Cytokinetics®