

MYQORZO™ Referral Form

Patient Information (REQUIRED)

Date: _____

Patient Name: _____ Date of Birth: _____ Sex: M F Last 4 Digits of SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Cell Ph: _____ Email: _____

Patient Weight: _____ lbs. Patient Height: _____ Date Taken: _____ Allergies: _____

Pharmacy Benefit Manager (REQUIRED) Please provide copies of both sides of the patient's card(s)

PBM Name: _____ Rx BIN# _____ PCN#: _____

Rx Group#: _____ Member ID#: _____

Medical/Health Insurance Info (REQUIRED) Please provide copies of both sides of the patient's card(s)

Primary: _____ Policy Holder: _____ Policy # _____ Ph: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary: _____ Policy Holder: _____ Policy # _____ Ph: _____

Address: _____ City: _____ State: _____ Zip: _____

Current Medication List

Diagnosis and Clinical Information

Only healthcare providers certified in the MYQORZO Risk Evaluation and Mitigation Strategy (REMS) Program are authorized to prescribe MYQORZO.
 ICD-10 Diagnosis Code: 142.1 Obstructive Hypertrophic Cardiomyopathy

Prescription Information: MYQORZO™ (aficamten)

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

Echocardiogram Benefits Investigation Echocardiogram Procedure Code required for Medical Benefits Investigation.

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

If the echocardiogram will be performed at a site different than the practice listed below, please include: _____

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

Physician Information (REQUIRED)

Prescriber Name: _____ Contact: _____

Email: _____ Street: _____ City: _____

State: _____ Zip: _____ Ph: _____ Fax: _____ NPI #: _____

Healthcare Professional Name (please print): _____

Healthcare Professional Signature: _____ **Date:** _____ / _____ / _____

By signing this form and utilizing our services, you are authorizing CareMed to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Please see full [Prescribing Information](#), including Boxed WARNING, and [Medication Guide](#).

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.