Bristol-Myers Squibb | PATIENT ASSISTANCE FOUNDATION

Sign-up Form for the Bristol-Myers Squibb Patient Assistance Foundation

What is the Bristol-Myers Squibb Patient Assistance Foundation?

- Bristol-Myers Squibb Company (BMS) established the Bristol-Myers Squibb Patient Assistance Foundation, Inc. (BMSPAF) to help patients who need help paying for medicines prescribed by their healthcare providers. BMSPAF is a non-profit organization that helps certain patients get, free of charge, the medicines that are listed in this application.
- Patients who meet certain rules will be able to get their prescribed medicines free of charge for up to one year. Every year, you must reapply, and be accepted, to continue in the program.
- Once approved, some medicines can be shipped to your home or to your healthcare provider's office.

What medications are available from the Foundation?

ELIQUIS® (apixaban)
DAKLINZA® (daclatasvir)
NULOJIX® (belatacept)
ORENCIA® (abatacept)

Am I able to get medication free of charge?

You may be able to get medicine free of charge through the Bristol-Myers Squibb Patient Assistance Foundation if:

- You are being treated as an outpatient with one of the medicines listed in this application.
- You live in the USA, Puerto Rico, or the U.S. Virgin Islands.
- You meet the income limits for your medicine.
- You do not have insurance coverage for your BMS medicines or you are signed up for a Medicare Part D plan and have spent at least 3% of your yearly household income on out-of-pocket costs for prescription medicines this year.
    - You can request a report from your pharmacy that shows your out-of-pocket costs (co-pays) for this year.
    - You can submit that report with your application.

These are just some of the eligibility requirements -- if you meet the criteria listed here, it does not guarantee you will be accepted.

How do I apply?

If you think you may be able to get medicines free of charge based on the criteria above, complete the form that follows, and return it by mail or fax to:

Bristol-Myers Squibb Patient Assistance Foundation
PO Box 220769
Charlotte, NC 28222-0769
Phone: 800-736-0003
Fax : 800-736-1611

✓ **If you have questions about the Bristol-Myers Squibb Patient Assistance Foundation or how to fill out the form, you can get in touch with the Foundation at 800-736-0003 between 8 a.m. and 8 p.m. Eastern Time Monday through Friday.**

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SECTION I: Patient Information (to be completed by patient)

Patient Name:	**Social Security Number:** *Providing Social Security Number is optional.	
Date of Birth:	**Gender:** ☐ Female ☐ Male	
Patient Address:		
City:	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	**Best Time to Call:**
Alternate Contact Name:	**Relationship:**	**Phone:**
Allergies:		
Current Medications:		

Do you have insurance through (check all that apply)?

☐ Medicaid	☐ Medicare A or B	☐ Medicare Part D
☐ VA or Military	☐ Private Insurance	☐ None
☐ State Assistance Program for Medication	☐ Other:	

Insurance Name	Phone #	ID/Policy #	Group #	Policy Holder
Primary:				
Secondary:				
Prescription Coverage:				

NUMBER OF PEOPLE IN YOUR HOUSEHOLD:
(Include yourself, your spouse and your dependents)

TOTAL ANNUAL HOUSEHOLD INCOME: $	**OR**	**MONTHLY INCOME:** $

- ✓ If you have a Medicare Part D plan & have spent 3% of your annual income on out-of-pocket prescription costs, please provide proof of those expenses. Your pharmacy can provide you with a report that shows what you have spent.
- ✓ BMSPAF may request proof of your income or audit your application.

Please continue to the next page to read and sign the Patient Agreement and Consent.

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Patient Agreement and Consent

By signing below:

I promise that:

- All of the information I provided in this sign-up form, and the copies of the income documents or other information about me that I may provide, are complete and true.
- If I am approved to get free medicine (enrolled), I agree to not get reimbursed for the free medicine from anyone else, including from a prescription insurance program or any other charity.
- If my insurance coverage changes in any way, I will immediately tell the Bristol-Myers Squibb Patient Assistance Foundation (BMSPAF).

I give my permission to:

- My insurance company and healthcare providers and others who may be helping me apply to this program to share information about me with BMSPAF and the companies that BMSPAF uses to administer the program for free medicine (its Administrators). My information that will be shared includes my personal information in this sign-up form, as well as my health information and records, insurance information, and financial and income information.
- BMSPAF and its Administrator to use my information, and share it with my healthcare providers, my insurance company, and other organizations or companies that might be able to help me, so that BMSPAF and its Administrators may:
  - Decide if I am eligible for this program,
  - Help me enroll (if I am eligible) and help get the free medicine to me for as long as I am enrolled, and
  - Find out whether I may be eligible for, or am already enrolled in, another program (including a prescription insurance plan or another charitable program).
- BMSPAF and its Administrators to obtain a consumer report on me. My consumer report, and information derived from public and other sources, will be used to estimate my income as part of the process to decide if I am eligible to receive free medication from BMSPAF. Upon request, BMSPAF will provide me the name and address of the consumer reporting agency that provides the consumer report. I may call BMSPAF at 800-736-0003 for this information.

I understand that:

- BMSPAF and its Administrators may ask for additional documents and information at any time, even if I am already enrolled, so that they can decide if the information on this sign-up form is complete and true.
- BMSPAF and its Administrators will only ask for the information that is needed to process my sign-up form, to help me with free medicine if I am enrolled, and to renew my sign-up form when my enrollment is going to end.
- If there is missing information on my sign-up form, if I have not provided the right income documents, or if I do not respond to requests for additional documents or information, BMSPAF and its Administrators can delay my enrollment, decide I am not eligible, or stop providing me with free medicine.
- If I am enrolled, BMSPAF will only give me free medicine for a short time and I will have to re-do my sign-up form before my enrollment ends if I still need help with free medicine.
- I may not be eligible for free medicine if I have prescription coverage that will pay for my medicine (other than Medicare Part D).
- I understand that once my information has been disclosed, privacy laws may no longer restrict its use or disclosure, but BMSPAF and its Administrators will only share my information as described in this consent form or as required or allowed by law.
- I may refuse to sign this consent form and 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 BMSPAF program.
- This consent form will be effective for 1 year unless it expires earlier by law or I cancel it in writing.
- I have the right to cancel this consent form at any time by writing to BMSPAF at the address in this sign-up form.
- If I cancel this consent form, I will no longer be eligible for this program and my enrollment will end.
- I have a right to receive a copy of this form after I have signed it.
- This program may be changed or stopped at any time without notice.

Print Patient Name: _____

Patient Signature: _____ **Date:** _____

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SECTION II: Treatment and Prescribing Information (to be completed by provider)

Patient Name:

MEDICATION WILL BE SHIPPED TO:
☐ Patient (available only for oral & subcutaneous injection medications)
☐ Healthcare Provider

Product Requested:

☐ DAKLINZA® (daclatasvir) ☐ ELIQUIS® (apixaban) ☐ NULOJIX® (belatacept) ☐ ORENCIA® (abatacept)*

* If you are prescribing a patient both ORENCIA SC and IV, please complete the physician-administered intravenous infusion section and include a prescription for ORENCIA SC.

For oral and subcutaneous (SC) injection medications: Please attach a new prescription for the patient named above. Prescriptions may be written for up to a 1-year supply, subject to eligibility period limits. Specify the number of refills needed. Up to a 90-day supply is available per shipment.

For physician-administered Intravenous Infusion medications: Provide the following information for up to a 4-week supply. If additional medication is needed after the initial shipment, orders must be requested from the Foundation.

Drug Name:_____ BSA/Weight_____ Patient ICD-9/Diagnosis:_____

Dose(s) and Dosing Schedule/Frequency:

Scheduled Administration Dates*:

* The BMSPAF may request proof of administration of product received through this program, including flow sheets.

SECTION III: Physician Information (to be completed by provider)

Physician Name:	**Physician State License #:**	**Physician NPI:**
Facility Name:	**Facility Phone:**	**Facility Fax:**
Facility Address, City, State & Zip:		
Primary Contact Name/Title:	**Primary Contact Phone:**	**Primary Contact Fax:**
Preferred Method of Contact ☐ Phone Only ☐ Fax Only ☐ Phone and Fax		
Facility Shipping Address:		
Shipping Contact Name:	**City:**	**State:** / **Zip:**
State License # of the Shipping Address Location *(if different from the Facility Address noted above)*		

I certify to the following: (1) Treatment with this medicine for this patient is medically necessary, based on my independent clinical judgment; (2) Information that I provide to BMSPAF, and in this form, is complete and accurate; (3) I have the authority to disclose this patient's information and I have obtained, if required by HIPAA or other applicable privacy laws, this patient's authorization; (4) To the best of my knowledge, this patient has no prescription insurance coverage (including Medicaid, Medicare, or other public or private programs), or is unable to afford the cost-sharing requirements associated with his/her insurance coverage, for this medication; (5) I will immediately notify BMSPAF if I become aware that this patient's insurance or income status has changed; (6) I will not submit an insurance claim or other claim for payment to any third-party payer (private or government), and I will forego any appeal of any denial of insurance coverage, for medication provided by BMSPAF for this patient; (7) Any medication provided by BMSPAF for this patient will not be resold, nor offered for sale, trade or barter, or returned for credit. I understand that: (1) BMSPAF reserves the right to verify all information provided by healthcare professionals, suspend participation where inadequate information is provided, and limit enrollment based on available resources; (2) BMSPAF reserves the right to modify or terminate this program, or recall or discontinue medications, at any time without notice; (3) BMSPAF, and its agents and assignees, are relying on the certifications in this form.
I authorize this prescription.

Physician Signature:_____ **Date:** _____
Physician or Licensed Prescriber Signature (required - no stamps)

PLEASE INCLUDE A PRESCRIPTION FOR THE PATIENT. Rx may be written for up to a 1-year supply. Specify the # of refills needed. Up to a 90-day supply is available per shipment.

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