Bristol-Myers Squibb
access | support®
YOUR PATIENT. OUR COMMITMENT.

Oncology Reimbursement Support
Phone: 1-800-861-0048 Fax: 1-888-776-2370
P.O. Box 221509
Charlotte, NC 28222-1509

Bristol-Myers Squibb Access Support® Program

- The Bristol-Myers Squibb Access Support Program is designed to help patients with reimbursement needs for certain Bristol-Myers Squibb (BMS) medications
- The program assists patients and their healthcare providers with the following services:
  - Insurance benefit investigations
  - Prior authorization and/or insurance appeal support
  - Referrals to a healthcare provider's preferred specialty pharmacy
  - Referrals to the BMS Oncology Co-Pay Program for patients who have commercial coverage for the medication but are in need of help in paying their out-of-pocket costs for treatment
  - Referrals to independent non-profit co-pay foundations that help patients who have coverage for their medications but need help paying for their out-of-pocket costs for treatment
  - Screening for the Bristol-Myers Squibb Patient Assistance Foundation (BMSPAF), an independent non-profit organization that helps eligible patients get, free of charge, the medications that are listed in this application

    Patients may be eligible if:
    - They do not have insurance coverage or have been denied coverage for the requested medication (before or after treatment), or they are enrolled in a Medicare Part D plan that covers the medication and have spent at least 3% of their yearly household income on out-of-pocket costs for prescription medications this year;
    - Are being treated as an outpatient;
    - Live in the USA, Puerto Rico, or the U.S. Virgin Islands; and
    - Meet the income limits for the requested medication

    Other eligibility criteria apply. BMS Access Support cannot guarantee acceptance by BMSPAF

What Medications does the BMS Access Support Program help with?

- DROXIA® (hydroxyurea)
- ERBITUX® (cetuximab)
- ETOPOPHOS® (etoposide phosphate)
- IXEMPRA® (ixabepilone)
- LYSODREN® (mitotane)
- OPDIVO® (nivolumab)
- SPRYCEL® (dasatinib)
- YERVOY® (ipilimumab)

Program Registration Steps

Once the Enrollment Form is received, your BMS Access Support representative will conduct the services requested and notify the healthcare provider of the results and provide additional assistance options that may be available

Healthcare Providers

- Select desired services at the top of registration form
- Complete appropriate Provider sections of the registration form
- Be sure to include treating physician's DEA#, state license number and NPI number
- If patient is applying for BMSPAF, complete the prescription information section
- If applying for the BMS Access Support Co-Pay program, please read and sign the Co-Pay agreement
- Have the patient read & sign the Patient Authorization & Agreement (PAA)
- Fax completed registration form to BMS Access Support at 1-888-776-2370

Patients

- Complete Patient section
- If applying for free product from BMSPAF, you may need to send your most recent Federal Tax Return or other proof of income upon BMSPAF request
- Read, sign and date the Patient Authorization on pages 4-5

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Selection of Services (to be completed by provider)

❒ Benefit Investigation / Prior Authorization / Appeals Assistance

Access to Care Services *Please choose all services you would like to use.*

❒ BMS Oncology Co-Pay Program (program available for Ixempra, Opdivo, and Yervoy)
Please read and sign the Co-Pay agreement. Applying for Co-Pay assistance does not guarantee receipt of acceptance into the program.

❒ Comprehensive Coverage Research
Research provides assistance to my patient in the nature of researching alternative methods of coverage of a BMS product

❒ Specialty Pharmacy Services (for Oral Medications Only)
Preferred Specialty Pharmacy: _____

❒ Screening for Bristol-Myers Squibb Patient Assistance Foundation (BMSPAF)

Product Prescribed (to be completed by provider)

❒ DROXIA® (hydroxyurea)
❒ ERBITUX® (cetuximab)
❒ ETOPOPHOS® (etoposide phosphate)
❒ IXEMPRA® (ixabepilone)
❒ LYSODREN® (mitotane)
❒ OPDIVO® (nivolumab)
❒ SPRYCEL® (dasatinib)
❒ YERVOY® (ipilimumab)

Treatment Information (to be completed by provider)

Patient Name_____
First Middle Initial Last

Patient Diagnosis: ICD-9 or ICD-10 Code _____Description _____

Will this be? ❒ Monotherapy ❒ In Combination With _____

Therapy Provided in: ❒ Doctor's Office ❒ Hospital ❒ Outpatient Facility

Is Doctor Contracted with Patient's Insurance? ❒ Yes ❒ No

Therapy GIVEN			Therapy PLANNED		
Dates	Dose	Frequency	Dates	Dose	Frequency

Erbitux-related testing:

KRAS Tested? ❒ Yes ❒ No If "Yes", what was the result? _____

EGFR Tested? ❒ Yes ❒ No If "Yes", what was the result? _____

Patient Information (to be completed by patient)

Personal Information

Name_____ Date of Birth _____/_____/_____
First Middle Initial Last

Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____

Patient E-mail Address _____

Social Security Number* _____ Gender: ❒ Female ❒ Male

*Providing Social Security Number is optional.

Allergies _____

Medications currently taking _____

Financial Information (complete if choosing Comprehensive Coverage Research or BMSPAF)

Number of people in your household _____ (Include yourself, your spouse and your dependents) Total household income: $_____ per month OR $_____ per year

Your application may be subject to audit or request for additional documentation.

Insurance Information

Do you have insurance through: (please check all that apply)

❒ Private Insurance ❒ VA or Military ❒ State Assistance program for medication ❒ Medicaid

Medicare: ❒ Part A ❒ Part B ❒ Part D ❒ Medicare Advantage ❒ None

Insurance Name	Phone	ID/Policy #	Group#	Policy Holder
Primary Insurance: Please list below				
Secondary Insurance: Please list below				
State, Veteran or other Prescription Coverage: Please list below				

If you chose Medicaid or Veteran status above, please choose applicable options below.

Medicaid Status ❒ Not Applied ❒ Denied ❒ Application Pending

Veteran Status ❒ Yes ❒ No Applied for VA ❒ Yes ❒ No

Please continue to the pages 4-5 to read and sign the Patient Authorization and Agreement.

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This page to be completed by the provider

Physician Information

Physician Name _____ State License # _____ Physician NPI # _____ Physician Tax ID # _____

Facility Name _____ Phone _____ Fax _____

Facility Address _____ City _____ State _____ Zip _____

Primary Contact Name _____ Phone _____ Fax _____

Primary Contact E-mail Address _____ Title _____

Preferred Method of Contact ❒ Phone Only ❒ Fax Only ❒ Phone and Fax

Prescription and Shipping Information (required only for BMSPAF screening)

Patient Name _____

For oral medications: Please attach a new prescription for the patient named in the treatment section. 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 at a time for SPRYCEL (dasatinib). Up to a 60-day supply is available at a time for DROXIA (hydroxyurea) or LYSODREN (mitotane).

Ship to: ❒ Healthcare Provider ❒ Patient (available only for SPRYCEL)

For physician-administered Intravenous Infusion medications: If approved for BMSPAF, a 4-week supply of medication will be shipped. Additional shipments will require the provider's confirmation of continued need for treatment. The BMSPAF may request proof of administration of product received, including flow sheets.

Drug Name: _____ BSA/Weight _____ Dose _____ Frequency of Administration _____ Anticipated Duration of Treatment _____

Shipping Facility Name (if different from above) _____

Shipping Facility Address (if different from above) _____ City _____ State _____ Zip _____

State License # of the Shipping Address Location (if different from above) _____

Provider Certification

I certify to the following: (1) To the best of my knowledge, the information in this form is complete and accurate; (2) I have the authority to disclose this patient's information to BMS, BMSPAF, and their respective agents and assignees, and I have obtained, if required by HIPAA or other applicable privacy laws, this patient's authorization; (3) I have prescribed the medication to this patient based on my professional judgment of medical necessity; (4) If this patient receives medication from BMSPAF, 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 my patient is enrolled in BMSPAF and I become aware that his/her 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 providers, suspend participation where inadequate information is provided, and limit enrollment based on available resources; (2) BMS and BMSPAF reserve the right to modify or terminate these programs, or recall or discontinue medications, at any time without notice; (3) BMS and BMSPAF are relying on the certifications in this form.

I authorize this prescription.

_____ **Date:** _____

Physician or Licensed Prescriber Signature (required - no stamps)

BMS Access Support® Oncology Co-Pay Program Agreement (for IXEMPRA, OPDIVO, & YERVOY only)

The BMS Oncology Co-Pay Program is designed to assist eligible patients who have been prescribed IXEMPRA, OPDIVO and YERVOY with out-of-pocket deductibles, co-pay, or co-insurance requirements.

BMS Oncology Co-Pay Program: Terms and Conditions

- This Program covers select BMS Oncology products. Please contact BMS Access Support for a complete list of covered products
- Enrolled patients pay the first $25 of their Co-Pay per infusion per product. BMS will cover the remaining amount up to $25,000 per product, per year
- This program will cover the out-of-pocket cost of the outpatient use of the BMS product only. It does not cover the cost of any other healthcare provider charges or treatment cost.
- The Program may apply to retroactive out-of-pocket expenses that occurred within 120 days prior to the date of enrollment, subject to the annual Program maximum of $25,000 per product, per year
- This offer is not valid for patients whose infusions are covered by a state or federal healthcare program which pays in whole or in part for prescription drugs such as Medicare, Medicaid, TRICARE, or VA programs, or where the entire cost of the infusion or monthly prescription is covered by commercial insurance. Patients may not submit a claim for reimbursement under any of these programs. Patients who move from commercial insurance to insurance through federal healthcare programs will no longer be eligible for the Program
- Patients who accept this offer confirm that the offer is consistent with his/her insurance and that he/she will report the value of the Co-Pay assistance as required by his/her insurance provider. Patients must not seek reimbursement from any healthcare reimbursement accounts or flexible spending accounts
- Patients must enroll by December 31, 2015
- Explanation of Benefits (EOB) must be submitted within 180 days post-infusion/prescription to receive Co-Pay assistance
- Proof required for payment must be a valid Explanation of Benefits (EOB) with product code-specific information. An EOB must be submitted regardless of assigned J-code
- This offer is valid only in the United States and Puerto Rico
- This offer is not an insurance benefit
- This offer is void where prohibited by law, taxed, or restricted
- This offer may not be combined with any other offer, rebate, coupon, or free trial
- This offer is non-transferrable
- Bristol-Myers Squibb reserves the right to rescind, revoke, amend, or terminate this offer or the Program in its entirety at any time
- Absent a change in Massachusetts law, effective July 1, 2015, Massachusetts residents will no longer be eligible to participate in the program

Healthcare Professional Certification Of Understanding Of The BMS Oncology Co-Pay Program

Thank you for your interest in the Bristol-Myers Squibb Oncology Co-Pay Program. As part of the Program, payment of up to $25,000 of the patient's cost share for infusions of a covered BMS product minus a patient responsibility of $25 per infusion of that product will be paid directly to the healthcare provider for eligible dates of service on behalf of the patient. BMS will contribute a maximum of $25,000 per product, per year, per patient.

The healthcare provider must provide a refund directly to the patient for copays the patient previously paid (minus their $25 responsibility) that are covered by the Program.

If after the Program has paid the Program maximum benefit per patient for infusions and there is an outstanding balance for any dates of service not covered under the Program, the doctor may hold the patient responsible for that remaining balance of valid cost share amounts.

Please sign and date below and fax back to BMS Access Support at 1-888-776-2370. We will be unable to process the patient's request for assistance until your certification is received. If you have any questions please call BMS Access Support at 1-800-861-0048. We are available to answer your call Monday through Friday, from 8:00 am to 8:00 pm Eastern Time (excluding holidays).

Patient Name: _____ Healthcare Provider Name: _____

✓ YES, Please enroll my patient in the Bristol-Myers Squibb Oncology Co-Pay Program

Certification

I certify that, to the best of my knowledge, the patient referenced above satisfies the previously listed set of criteria and that I have read and agree to all of the terms and conditions of the program. I represent that the patient information I provided is consistent with applicable privacy laws and regulations, and I understand that Bristol-Myers Squibb and/or its agents are relying on this representation. I understand that the Bristol-Myers Squibb Oncology Co-Pay Program or one of its agents may contact this office/site to verify information about this patient's treatment with a covered BMS product specific to this program.

I certify that, 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 IXEMPRA, OPDIVO, or YERVOY administered to the patient. I certify that this office/site will comply with applicable obligations, if any, to disclose participation in this program to the applicable payers. I also certify that the bill or claim that this office/site will submit to the insurer or patient for payment for a covered BMS product will have a covered BMS product listed separately from any bill or claim for drug administration or any other items or services provided to the patient.

I further certify that no reimbursement of the cost of product will be accepted by me from the patient for any treatment that is the subject of payment from the Bristol-Myers Squibb Oncology Co-Pay Program. If funds have already been received from the patient for their share of the cost of a covered BMS product (minus $25 per treatment) for any dates of service paid through the BMS Oncology Co-Pay Program, I will ensure payment is made back to the patient.

✓ Please check the appropriate box below:

❒ The patient's share of cost of a covered BMS product is unpaid. (Payment is not more than $25 per infusion, if applicable.) Please send the amount provided by the BMS Oncology Co-Pay Program directly to the physician at the address specified on the application

❒ The patient's share of cost of a covered BMS product has been paid. Please send the amount provided by the BMS Oncology Co-Pay Program directly to the patient at the address specified on the application

_____ _____

Prescribing Physician's Signature **Date**

The Program reserves the right to not provide cost sharing assistance until an accurate and complete certification is received from the physician, along with any other required documentation.

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Patient Authorization and Agreement

The BMS Access Support® program is a support program by Bristol-Myers Squibb Company (BMS) that helps patients understand their insurance coverage and financial support options for BMS medications as well as performs screening for patient assistance from the Bristol-Myers Squibb Patient Assistance Foundation, Inc. (the Foundation), an independent, non-profit that provides free medication to qualifying patients. To participate in the BMS Access Support program or to apply for the Foundation program, these programs will need to receive, use, and disclose your personal information.

Please read this authorization for BMS and the Foundation carefully and contact BMS at 1-800-861-0048 if you have any questions. Once you have read and agreed to this form, fax your signed copy to 1-888-776-2370.

1) What information will be used and disclosed? My personal information will be disclosed, including:

- Information on this application form
- My contact information and date of birth
- Social security number (which is voluntary)
- Financial and income information
- Insurance benefit information
- Health records and information, including medications prescribed to me
- Genetic 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, pharmacists, health plans, and health insurers who provide services to me, as well as other people that I say can help me apply, to disclose my personal information to BMS, the Foundation, and their authorized agents and assignees (their "Administrators"). BMS and the Foundation and their Administrators may also share my information with my 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 the persons and organizations described in this authorization in order to:

- Process my application for both the BMS Access Support and Foundation programs
- Provide the BMS Access Support program services to me, including verifying my insurance benefits, researching insurance coverage options, and referring me to other plans or assistance programs that may be able to help me
- Provide co-pay assistance to me, if I am eligible
- Contact my caretakers and me about the programs and the services that are available
- Contact other healthcare providers and charitable organizations to determine if I am eligible for, or enrolled in, another plan or program
- Provide me with free medication through the Foundation program, if I qualify
- Improve or develop the programs' services

4) When will this authorization expire? This authorization will be effective for 2 years unless it expires earlier by law or I cancel it in writing. I may cancel this authorization for either or both programs by writing to:

BMS Access Support
P.O. Box 221509
Charlotte, NC 28222-1509

If I cancel this authorization for a program, I will no longer be able to participate in that program. That 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. I understand that to participate in the Foundation program, I must reapply at least every year, sign an authorization for both the BMS Access Support and Foundation programs, and be accepted.

Patient Name: _____

(continued on next page)

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5) Notices

I understand that once my health information has been disclosed, privacy laws may no longer restrict its use or disclosure. BMS, the Foundation, and their Administrators agree to use and disclose my information only for the purposes described in this authorization or as allowed or required by law. 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 BMS Access Support or Foundation programs. I have a right to receive a copy of this authorization after I have signed it.

6) Authorization for a Consumer Report (for Patients applying or referred to the Foundation program)

I authorize the Foundation 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 determine if I am eligible to receive free medication from the Foundation. Upon request, the Foundation will provide me the name and address of the consumer reporting agency that provides the consumer report. I may call the Foundation at 1-800-736-0003 for this information.

7) Patient Certifications

I certify that the personal information that I provide to the BMS Access Support program and the Foundation program is true and complete.

I agree that, at any time during my participation in either or both programs, the BMS Access Support (and the Foundation program, if applicable) may request additional documentation to verify my personal information. If there is missing information or I do not respond to requests for additional documents, these programs may delay my participation or decide I can no longer participate.

If I qualify for and receive copay assistance from BMS Access Support, I agree to comply with the copay assistance Terms and Conditions and I will not get reimbursed for the assistance I receive from anyone else, including from an insurance program, another charity, or from a health savings, flexible spending, or other health reimbursement account. I will contact BMS Access Support at 1-800-861-0048 if my insurance coverage changes in any way.

If I qualify for and receive free product from the Foundation program, I agree that I will not get reimbursed for it from anyone else, including from an insurance program, another charity, or from a health savings, flexible spending, or other health reimbursement account. I understand that the Foundation's help is temporary, I must reapply every year, and I may not be eligible if I have prescription drug coverage that will pay for my medication. I agree to immediately contact the Foundation at 1-800-736-0003 if my insurance or financial situation changes in any way.

I understand that the BMS Access Support and the Foundation programs may be discontinued or the rules for participation may change at any time, without notice.

SIGNATURE

I have read this authorization and agree to its terms:

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

_____

Signature of Patient or Personal Representative Date

The patient or his/her personal representative must be provided with a copy of both pages of this form after it has been signed.

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