Bristol-Myers Squibb | PATIENT ASSISTANCE FOUNDATION

APPLICATION FORM

The Bristol-Myers Squibb Patient Assistance Foundation, Inc. (BMSPAF) is a non-profit organization that seeks to help eligible patients get the medicines listed below for free.

ELIQUIS® (apixaban) **NULOJIX® (belatacept)** **ORENCIA® (abatacept)**

ELIGIBILITY

You may be eligible to receive free medicine from BMSPAF if:

- You live in the USA, Puerto Rico, or the U.S. Virgin Islands, and
- You have a prescription from and are being treated by a doctor licensed in the US, and
- You are being treated with the medicine as an outpatient, and
- Your yearly household income is below the Foundation's limits, and
- You do not have insurance coverage for the medicine ***or*** you, and the medicine you are requesting is covered by a Medicare Part D plan and you have spent at least 3% of your yearly household income on out-of-pocket prescription expenses this year.

BMSPAF may request proof of income (such as a copy of your federal tax return, social security statement or other documents), and proof of amount of out-of-pocket prescription expenses (such as a pharmacy print-out).
These are a few of the eligibility requirements. Meeting these requirements does not guarantee you will be accepted.

TO APPLY: Complete the following form 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 (Monday to Friday, 8am – 8pm ET, excluding holidays)
Fax : 800-736-1611

Applying directly to the BMS PAF is free. There is no charge to submit your application form.

PATIENT & PROVIDER INFORMATION CHECKLIST:

PATIENTS: COMPLETE SECTION I*:

- ☐ Patient Information
- ☐ Insurance Information
- ☐ Household Size & Income
- ☐ **Sign & Date Patient Agreement & Consent**

PROVIDERS:COMPLETE SECTIONS II* & III*

- ☐ Treatment and Prescription Information
- ☐ Provider & Facility Information
- ☐ Shipping Address (if different)
- ☐ **Sign & Date Prescriber Certification**
- ☐ **Prescription attached**

⚠ ***PLEASE NOTE: If requested information is missing from your application, our response to your application will be delayed.***

Bristol-Myers Squibb Patient Assistance Foundation Application Form

BMSPAF CASE#:<Patient Case #> PO Box 220769, Charlotte, NC 28222-0769 Phone 800-736-0003 Fax 800-736-1611

SECTION I: Patient Information (To be completed by Patient. All boxes are required except where noted)

Patient Name:	**Social Security Number:** *Providing SSN is optional	
Date of Birth:	**Gender:** ☐ **Female** ☐ **Male**	
Patient Address:		
City:	**State:**	**Zip:**
Is this a seasonal address? ☐ **Yes** ☐ **No**		
Home Phone:	**Cell Phone:** *optional	**Email Address:** *optional
Alternate Contact Name: *optional	**Relationship:** *optional	**Phone:** *optional
Allergies (you may attach a list if more space is needed):		
List All Current Medications (you may attach a list if more space is needed):		

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 #
Primary:		
Secondary:		
Prescription Coverage: (Optional: Attach a copy of both sides of your prescription insurance card)		**ID/Policy #:** **RxBIN:** **RxPCN:**

REQUIRED: Number of people living in your home:
(Include yourself, your spouse and your dependents)

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

✓ **Proof of income may be required:** Please provide your most recent federal tax return. If your federal tax return is not available, please provide as many of the following as available: W2, 1099, pension statement, social security statement, at least 2 consecutive pay stubs

✓ **Medicare Part D recipient**: If you have spent 3% of your annual income on out-of-pocket prescription costs, please contact your pharmacy to provide you with a report to document your yearly out of pocket expenses. Report must be attached to this application.

⚠ **Please continue to the next page to read, sign and date the Patient Agreement and Consent**

Bristol-Myers Squibb Patient Assistance Foundation Application Form

Patient Agreement and Consent

I promise that:

- All of the information I provided in my application, and other documents or information that I may provide, are complete and true.
- If I am approved (enrolled), I agree that I will not be reimbursed for the free medicine from anyone else, including a prescription insurance program or any other charity. If I have Medicare Part D, I will not count any free medicine towards my true out-of-pocket costs (TrOOP).
- If my insurance coverage or income changes in any way, I will immediately notify BMSPAF.

I give my permission to:

- My insurance providers, healthcare providers, and others helping me apply to this program, to share information about me with BMSPAF and the companies that BMSPAF uses to administer the program (Administrators). My information that will be shared includes my personal information in my application, as well as my health information and records, insurance information, and financial and income information.
- BMSPAF and its Administrators 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 the program, help me get the free medicine (if I am eligible) during my enrollment, and find out if I may be eligible for, or 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 medicine 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 contact me by phone or other methods to ask for additional information at any time, even if I am enrolled, so that they can decide if the information on my application is complete and true.
- BMSPAF and its Administrators may delay, deny or end my enrollment, if my application is missing information or I do not respond to requests for documents or information.
- If I am enrolled, BMSPAF will only give me free medicine for a short time and I will have to reapply before my enrollment ends if I still need help with free medicine.
- I may not be eligible for free medicine if I have insurance coverage that will pay for my medicine (other eligible patients covered under Medicare Part D).
- I understand that once my information has been disclosed, privacy laws may no longer restrict its use or disclosure. BMSPAF and its Administrators will 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 this program.
- This consent will be effective for 18 months unless it expires earlier by law or I cancel it in writing. I may cancel this consent at any time by writing to BMSPAF at the address in this application. If I cancel this consent, I will no longer be eligible for the program and my enrollment will end.
- I have a right to receive a copy of this form after I have signed it.
- BMSPAF may change or stop the program at any time without notice.

⚠ **You must Sign & Date to apply**

Print Patient Name: _____

Patient Signature: _____ **Date:** _____

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BMSPAF Case #: <Patient Case #> PO Box 220769 Charlotte, NC 28222-0769 Phone 800-736-0003 Fax 800-736-1611

Section II: Prescription -to be completed by licensed prescriber - MD or NP (where permitted). Same person should also sign this enrollment form. (All boxes are required except where noted)

Patient Name:	**DOB:**
Product Name:	

ELIQUIS®(apixaban)

Dosage_____

Sig _____

Qty _____

Days Supply ☐ **90** ☐ **60** ☐ **30**

☐ **Other**____

Number of Refills_____

Rx may be written for up to a 1-year supply (refills are subject to eligibility period limits). Specify number of refills needed. Shipping Limits: Up to a 90-day supply available.

ORENCIA® (abatacept)* *If you are prescribing both ORENCIA SC and IV, please include a prescription for both.*

Age_____ **BSA/Weight**_____ **ICD code**_____

Orencia SC

Dosage_____ **Sig** _____**Qty** _____

Days Supply ☐ **90** ☐ **60** ☐ **30** ☐ **Other**____

Number of Refills_____

Rx may be written for up to a 1-year supply (refills are subject to eligibility period limits). Specify number of refills needed. Shipping Limits: Up to 30-day supply if shipped to patient/Up to 90-day supply if shipped to provider.

Orencia IV: **Dose(s) and Dosing Schedule/Frequency**:

Complete for **up to a 4-week supply** If additional medication is needed after initial shipment, orders must be requested from the Foundation.

NULOJIX®(belatacept)

ICD code

_____

BSA/Weight

_____

Dose(s) and Dosing Schedule/Frequency:

Complete above for **up to a 4-week supply.** If additional medication is needed after initial shipment, orders must be requested from the Foundation.

Section III. Ship Medicine to:

☐ Healthcare Provider (provide shipping address in Section III) ☐ Patient (for oral & subcutaneous injection (SC) medicines only)

Physician Name:	**Physician State License #:**	**Physician NPI:**
Facility Name:	**Facility Phone:**	**Facility Fax:**
Facility Address, City, State & Zip:		
Is this address where medicines should be shipped? ☐ Yes ☐ No *-- Provide Shipping Address of Facility receiving medicines*	**Is patient receiving treatment at an outpatient facility** ☐ Yes ☐ No	
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)*		

Provider Certification. 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, nor will I count the free medicine towards this patient's true out-of-pocket costs (TrOOP); (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.

Prescriber Signature:_____ **Date:** _____

⚠ **Application must be signed & dated by a licensed prescriber - No Stamps.**