Bristol-Myers Squibb
access|support®

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 Assistance 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 Adjuvant Patient Program for Melanoma
  - 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)
- EMPLICITI™ (elotuzumab)
- ETOPOPHOS® (etoposide phosphate)
- LYSODREN® (mitotane)
- OPDIVO® (nivolumab)
- OPDIVO® (nivolumab) + YERVOY® (ipilimumab) Regimen
- 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 Assistance 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 EMPLICITI, OPDIVO, OPDIVO + YERVOY REGIMEN, 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 medication.

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

❒ **Screening for Adjuvant Patient Program for Melanoma**
Completed Access Support form required. Upon review of screening, you will be asked to complete an additional application (program available only for YERVOY 10 mg/kg).

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

Medication Prescribed (to be completed by provider)

❒ DROXIA® (hydroxyurea)
❒ EMPLICITI™ (elotuzumab)
❒ ETOPOPHOS® (etoposide phosphate)
❒ LYSODREN® (mitotane)
❒ OPDIVO® (nivolumab)
❒ OPDIVO® (nivolumab) + YERVOY® (ipilimumab) Regimen
❒ SPRYCEL® (dasatinib)
❒ YERVOY® (ipilimumab)

Treatment Information (to be completed by provider)

Patient Name _____
First Middle Initial Last

Patient Diagnosis: ICD 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

Previous Therapy Given*			Planned Therapy*		
Dates	Dose *(in mg)*	Frequency	Dates	Dose *(in mg)*	Frequency

*Include combination medications if relevant.

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 _____

Prescription and Shipping Information (required only for BMSPAF screening and must be completed for review by BMSPAF)

Patient Name _____

Drug Name _____ BSA/Weight _____ Full Dosage (*in mg*) _____ Frequency of Administration _____ Number of Refills _____ QTY (oral only) _____

For oral medications (DROXIA, LYSODREN, & SPRYCEL): 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.

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, treatment, or income status has changed; (6) I will not submit an insurance claim or other claim for payment to anyone else, including a third-party payer (private or government) or the patient, and I will forego any appeal of any denial of insurance coverage, for medication provided by either BMS or BMSPAF for this patient; (7) Any medication provided by either BMS or BMSPAF for this patient will be used only for this patient and will not be resold, nor offered for sale, trade or barter, or returned for credit; (8) I will store BMS or BMSPAF medication I receive for this patient separate from commercially-purchased medication that is used for the treatment of other patients; (9) I will confirm each administration of medication and agree to provide to BMS and BMSPAF proof of administration, when requested; (10) I will notify BMS or BMSPAF if any free product will not be administered to this patient and arrange for BMS or BMSPAF to pick up such product. If I do not permit the return of any free unopened vials provided and not used by this patient, I will pay for them; and (11) I will discard any unused amounts in opened vials.

I understand that: (1) BMS and 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 and; (3) BMS and BMSPAF are relying on the certifications in this form.

I authorize this prescription.

_____ _____

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

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BMS Access Support® Oncology Co-Pay Assistance Program Agreement (for EMPLICITI, OPDIVO, OPDIVO + YERVOY REGIMEN, & YERVOY only)

The BMS Oncology Co-Pay Assistance Program is designed to assist eligible commercially-insured patients who have been prescribed select BMS medications with out-of-pocket deductibles, co-pay, or co-insurance requirements.

Eligibility Terms and Conditions

Patient Eligibility:

- You have commercial insurance that covers your prescribed medication, but your insurance does not cover the full cost; that is, you have a co-pay obligation for your prescribed medication.
- You are not participating in any state or federal healthcare program including, for example, Medicaid, Medicare, Medigap, CHAMPUS, DOD, VA, TriCare, or any state, patient, or pharmaceutical assistance program; Patients who move from commercial insurance to a state or federal healthcare program will no longer be eligible.
- You live in the United States or Puerto Rico.

Program Benefits:

- The patient must pay the first $25 of the co-pay for each dose of a BMS medication covered by this Program. If the patient is administered two BMS medications covered by this Program on the same day, the combination of those two medications will be treated as one dose, requiring the patient pay only $25 of the medications' co-pay for that day. The Program will cover the remainder of the co-pay, up to a maximum of $25,000 per BMS medication during a 12-month enrollment period. (For clarification, if a patient is prescribed two BMS medications in combination, the maximum is $50,000). Patients are responsible for any costs that exceed the Program's per medication $25,000 maximum.
- In order to receive the Program benefits, the patient or provider must submit an Explanation of Benefits (EOB) form. The submitted form must include the name of the insurer, plan information, and show that the BMS medication supported by this Program was the medication that was given. The form must be submitted within 180 days of receiving each dose.
- The Program may apply to retroactive out-of-pocket expenses that occurred within 120 days prior to the date of the enrollment. These benefits are subject to the $25 patient co-pay requirement and the 12-month Program maximum of $25,000 per medication.
- The Program benefits are limited to the co-pay costs for BMS medications covered by this Program that the patient receives as an outpatient. The Program will not cover, and shall not be applied toward, the cost of any dosing procedure, any other healthcare provider service or supply charges or other treatment costs, or any costs associated with a hospital stay.

Program Timing:

- The enrollment period is 12 months from the date of enrollment.
- Patients must enroll by December 31, 2016.
- Absent a change in Massachusetts law, effective July 1, 2017, Massachusetts residents will no longer be able to participate in this Program.

Additional Terms and Conditions of Program:

- Patients, pharmacists, and healthcare providers must not seek reimbursement from health insurance or any third party for any part of the benefit received by the patient through this Program. Patients must not seek reimbursement from any health savings, flexible spending, or other healthcare reimbursement accounts for the amount of assistance received from the Program.
- Acceptance of this offer confirms that this offer is consistent with your insurance and that you will report the value of the co-pay assistance you receive as may be required by your insurance provider.
- This offer is not valid with any other program, discount, or incentive involving a BMS medication eligible for this Program.
- Only valid in the United States and Puerto Rico; this offer is void where restricted or prohibited by law, taxed or restricted.
- The Program benefits are nontransferable.
- No membership fees.
- This offer is not conditioned on any past, present, or future purchase, including additional doses.
- **The Program is not insurance**
- Bristol-Myers Squibb reserves the right to rescind, revoke, or amend this offer at any time without notice.

Physician Certification

Please check the appropriate box below:

❒ The patient's co-pay (except for the first $25) will not be paid. Please send the amount provided by the BMS Access Support Co-Pay Assistance Program directly to the physician at the address specified on the application

❒ Co-pay will be paid to the provider. Please send the amount provided by the BMS Access Support Co-Pay Assistance Program directly to the patient at the address specified on the application

I certify to the following:

(1) To the best of my knowledge, the patient and physician information in this form is complete, and accurate. **(2)** I have the authority to disclose this patient's information and have obtained, if required by HIPAA or other applicable privacy laws or regulations, this patient's authorization for the disclosure. **(3)** To the best of my knowledge, this patient satisfies the Eligibility criteria and I will immediately notify the Program if I become aware that this patient's insurance or income status has changed. **(4)** I have read and agree to all of the Terms and Conditions of the Program. **(5)** 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 a covered BMS medication administered to the patient. **(6)** This office/site will comply with applicable obligations, if any, to disclose participation in this Program to the applicable payers. **(7)** The bill or claim that this office/site will submit to the insurer or patient for payment for a covered BMS medication will have a covered BMS medication listed separately from any bill or claim for drug administration or any other items or services provided to the patient. **(8)** 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. **(9)** 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 will ensure payment is made back to the patient if funds have already been received from the patient for their share of the cost of a covered BMS medication (minus $25 per treatment) for any dates of service paid through the Program.

I understand that:

(1) BMS 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 reserves the right to modify or terminate this Program, or recall or discontinue medications, at any time without notice. **(3)** BMS is relying on the certifications in this form. **(4)** The Program reserves the right to not provide assistance until an accurate and complete application with a signed certification is received, along with any other required documentation.

Please sign and date below and fax back to the BMS Access Support Co-Pay Assistance Program at 1-888-776-2370. An original physician signature is required. Stamped signatures or signatures by persons other than the prescribing healthcare physician are not acceptable. We will be unable to process the patient's request for assistance until we receive a complete application with your certification and the patient's signature and proof of income. If you have any questions please call the BMS Access Support Co-Pay Assistance Program 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's Name (Please Print)	**Original Signature of Prescribing Physician**	**Prescribing Physician's Name** (Please Print)	**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, such as copay and free medication assistance. BMS also screens 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.

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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 from BMS or the Foundation, 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 if I receive financial support (copay assistance or free medication), I must reapply at least every year, sign an authorization for both BMS Access Support and the Foundation, and be accepted.

(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 BMS and the Foundation is true and complete. I agree that, at any time during my participation in either or both programs, BMS (and the Foundation, 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, my participation may be delayed or I may no longer be able to participate.

If I qualify for and receive copay assistance or free medication assistance from BMS, I agree to comply with BMS' program rules 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 understand that assistance may be temporary and that I may be required to apply every year. I will contact BMS Access Support at 1-800-861-0048 if my insurance or treatment changes in any way.

If I qualify for and receive free product from the Foundation program, I agree to comply with the Foundation's program rules 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 pending, 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, treatment, 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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