Bristol-Myers Squibb
access|support®

Rheumatology Access and Reimbursement Support

1-800-861-0048 1-866-268-5385

Simple Steps to Enroll

Physician

- ☐ Complete the Services, Treatment, and Site of Care (if applicable) Sections on page 1
- ☐ Complete the Physician Information section on page 2
- ☐ Read, sign, and date the Physician Certification on page 2
- ☐ Have the patient fill out the Financial Information section on page 3 if requesting Alternative Coverage or Support Research

Patient

- ☐ Complete the Patient Information section on page 3
- ☐ If enrollment into the BMS Rheumatology IV Co-Pay Assistance Program is requested, please read the Program Terms and Conditions on page 4
- ☐ If requesting Alternative Coverage or Support Research, complete the Financial Information section on page 3
- ☐ Read, sign, and date the Patient Authorization and Agreement (PAA) on page 6 (initial page 5)

FAX completed and signed enrollment form to BMS Access Support® at 1-866-268-5385

What to Expect After Enrollment

Physician

Your BMS Access Support representative will:

- Provide benefit review results within 24 hours (within one business day upon receipt of a completed enrollment form)
- Provide additional assistance options that may be available, if requested

Patient

- Your physician's office will inform you of the results of the benefit review when received
- If co-pay assistance is requested, you will receive a letter informing you of eligibility if accepted

Thank you for taking the time to complete this enrollment form.
If you have any questions, please contact BMS Access Support at 1-800-861-0048.

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Reset Form

Services–to be completed by Physician

Services Requested (Please choose all services desired.)

- ☐ **Benefits Review, Prior Authorization, Appeals Assistance**
- ☐ BMS Rheumatology IV Co-Pay Assistance Program
- ☐ **Specialty Pharmacy Coordination**
  (for subcutaneous patients only)
  Preferred Specialty Pharmacy: _____
- ☐ **Alternative Coverage or Support Research**
  (eg, independent charitable foundation referral)
- ☐ **Site of Care Services**
  (for IV patients only)
  Choose if you or your patient need assistance locating an alternate site of care

BMS cannot guarantee acceptance by any program or foundation.

Treatment–to be completed by Physician

Medication Prescribed

- ☐ ORENCIA® (abatacept) Intravenous
- ☐ ORENCIA® (abatacept) Subcutaneous* (SC)—new to therapy
- ☐ ORENCIA® (abatacept) Subcutaneous* (SC)—transitioning from IV
- ☐ ORENCIA® (abatacept) Subcutaneous* (SC)—new to therapy with IV loading dose

***If prescribing SC method above, please indicate one or both administration forms desired:** ☐ Prefilled Syringe ☐ Clickject™ Autoinjector

Treatment Information

Patient Diagnosis: ICD Code _____ Description _____

Site of Care Services (IV patients only)–to be completed by Physician

(**Required** if Site of Care Services are requested)

Please indicate alternate site preference, if any:

- ☐ Non-prescribing MD's Office
- ☐ Hospital Outpatient Facility
- ☐ Home infusion/Infusion Provider Company
- ☐ Other

If alternate site of service is known please fill out below:

Physician or Provider Name _____
First name Last name

Practice/Facility Name _____

Facility Address _____ City _____ State _____ Zip _____

Primary Contact Name _____ Phone _____ Fax _____

Insurance Provider # _____ Tax ID # _____

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Physician Information–to be completed by Physician

Physician Name _____
First name Last name

State License # _____ Physician NPI # _____

Physician Tax ID # _____ State Medicaid # _____

Facility Name _____ Phone _____ Fax _____

Facility Address _____ City _____ State _____ Zip _____

Primary Contact Name _____ Phone _____ Fax _____

Primary Contact E-mail Address _____ Title _____

Physician Information–to be completed by Physician

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 to BMS and its respective agents and assignees, and I have obtained this patient's authorization for the disclosure, if required by HIPAA or other applicable privacy laws; and (**3**) I have prescribed the medication to this patient based on my professional judgment of medical necessity.

I certify, if the patient enrolls in the BMS Access Support Rheumatology IV Co-Pay Assistance Program, to the following:

- I have read and will comply with the Program Terms and Conditions on page 4
- To the best of my knowledge, this patient satisfies the Patient Eligibility requirements, and I will notify the Program immediately if the patient's insurance status changes
- 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 the covered BMS medication(s) administered to the patient
- The bill or claim that this office/site will submit to the insurer or patient for payment for BMS medication(s) will have the BMS medication(s) listed separately from any bill or claim for drug administration or any other items or services provided to the patient
- 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
- 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 understand that BMS (1) may verify all information provided, and not allow or suspend participation if inadequate information is received; (2) may modify, limit, or terminate these programs, or recall or discontinue medications, at any time without notice; and (3) is relying on these certifications.

SIGNATURE _____ Date _____

Physician or Licensed Prescriber signature (required—no stamps)

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Patient Information–to be completed by Patient

Personal Information

Patient name _____ _____ ☐ Male ☐ Female Birth date __/__/__
First name Last name

Address _____ City _____ State _____ Zip _____

Home phone _____ Mobile _____

Insurance Information

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

☐ Private/Employer-based insurance ☐ VA or military ☐ State assistance program for medication ☐ Medicaid

Medicare – ☐ Part A ☐ Part B ☐ Part D ☐ Medicare Advantage ☐ None

Primary insurance carrier _____ Primary insurance policy # _____

Phone _____ Group # _____ Policy holder _____

Secondary insurance carrier _____ Secondary insurance policy # _____

Phone _____ Group # _____ Policy holder _____

State, Veteran, or Other Prescription Coverage _____ Prescription Policy # _____

Phone _____ Group # _____ Policy holder _____

Prescription drug insurer _____ Card/bin# _____ Phone # _____

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

Financial Information–to be completed by Patient

(**Required** if Alternative Coverage or Support Research is requested)

Number of people in your household ___ (Include yourself, your spouse, and your dependents)

Yearly household income: $ _____ or Monthly household income: $ _____

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

Social Security # (*optional*) _____

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BMS Access Support® Rheumatology IV Co-Pay Assistance Program Terms & Conditions

The BMS Rheumatology IV Co-Pay Assistance Program is designed to assist eligible commercially insured patients who have been prescribed a BMS rheumatology IV medication with out-of-pocket deductibles, co-pay, or co-insurance requirements.

Patient Eligibility:

- You have commercial (private) insurance that covers your prescribed Bristol-Myers Squibb (BMS) medication, but your insurance does not cover the full cost; that is, you have a copay obligation (out-of-pocket cost) for your prescribed medication.
- You are not participating in any state or federal healthcare program including Medicaid, Medicare, Medigap, CHAMPUS, TriCare, Veterans Affairs (VA), or Department of Defense (DoD), or any state, patient, or pharmaceutical assistance program. Patients who move from commercial (private) insurance to a state or federal healthcare program will no longer be eligible. If you purchased your prescription insurance through a Health Exchange (also known as a Health Insurance Marketplace or Small Business Options Program [SHOP] Marketplace), you are currently eligible.
- You live in the United States or Puerto Rico.

Program Benefits:

- Patient must pay the first $5 of the co-pay for each dose of a BMS medication covered by this Program. This Program will cover the remainder of the co-pay, up to a maximum of $15,000 during a calendar year. Patients are responsible for any costs that exceed the Program's $15,000 maximum.
- In order to receive the Program benefits, the patient or provider must submit an Explanation of Benefis (EOB) form, or a Remittance Advice (RA). 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 retroactively to out-of-pocket expenses that occurred within 120 days prior to the date of the enrollment. These benefits are subject to the $5 patient co-pay requirement and the 12-month Program maximum of $15,000.
- 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, supply charges or other treatment costs, or any costs associated with a hospital stay.
- Program payments are for the benefit of the patient only.

Program Timing:

- The enrollment period is 1 calendar year.
- Patients must enroll by December 31, 2019.
- Absent a change in Massachusetts law, effective July 1, 2019, 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 patient's insurance. Patients, pharmacists, and healthcare providers must report the receipt of co-pay assistance benefits as may be required by patient's 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 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.

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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 co-pay and free medication assistance. To participate in the BMS Access Support program, this program will need to receive, use, and disclose your personal information. Please read this authorization 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 1-866-268-5385.

1. What information will be used and disclosed?

My personal information will be disclosed, including:

- Information on the BMS Access Support enrollment 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

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 and its authorized agents and assignees (its "Administrators"). BMS and its 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 the BMS Access Support program
- 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
- Improve or develop the programs' services

4. When will this authorization expire?

This authorization will be effective for 5 years unless it expires earlier by law or I cancel it in writing. I may cancel this authorization by writing to:

BMS Access Support
P.O. Box 220745
Charlotte, NC 28222-0745

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.

(continued on next page)

Patient or Personal Representative Initials _____

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Patient Authorization and Agreement (cont'd)

5. Notices

I understand that once my health information has been disclosed, privacy laws may no longer restrict its use or disclosure. BMS and its 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 program. I have a right to receive a copy of this authorization after I have signed it.

6. Patient certifications

I certify that the personal information that I provide to BMS is true and complete. I agree that, at any time during my participation in BMS Access Support, BMS 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 co-pay assistance from BMS, I agree to comply with the program 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 or treatment changes in any way.

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

I have read this authorization and agree to its terms:

Print Name of Patient or Personal Representative _____

Description of Personal Representative's Authority _____

Preferred E-mail Address _____

ZIP Code _____ Patient Date of Birth _____ Initials _____

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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