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, most medicine will be shipped to your home or to your healthcare provider's office.

What medications are available from the Foundation?

ABILIFY® (aripiprazole)
BYDUREON® (exenatide extended-release for injectable suspension)
BYETTA® (exenatide)
ELIQUIS® (apixaban)
KOMBIGLYZE™ XR (saxagliptin and metformin HCl extended-release)
NULOJIX® (belatacept)
ONGLYZA® (saxagliptin)
ORENCIA® (abatacept)
SymlinPen® (pramlintide acetate) Pen Injector

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 will need to send your most recent Federal Tax Return or other proof of income.
- 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.

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 with your proof of income statement 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

- ✓ **Don't forget to sign the form and submit your proof of income.**
- ✓ **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)

Personal Information

Name _____ **Date of Birth**_____/_____ / _____
First Middle Initial Last

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone (_____) _____ **Cell Phone (_____)** _____

Social Security Number _____ **Gender:** ☐ **Female** ☐ **Male**

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

What is the total combined household income? $_____ per month **OR $**_____ per year

- ✓ **Please include a copy of your most recent Federal Tax Return, Social Security Statement, or other documents that support the income amount provided above.**
- ✓ **If you have indicated no income ($0), your application may be subject to audit or request for additional documentation.**

Allergies _____

Medications currently taking _____

Insurance Information

Do you have coverage for prescription medications through (check all that apply)**?**

☐ **Medicaid**	☐ **Private Insurance**	☐ **State assistance program for medication**
☐ **Medicare A or B**	☐ **VA or Military Benefits**	☐ **None**
☐ **Medicare Part D**		

If you do have coverage for prescriptions, please provide the following information.

Name of Insurance Company _____ **Phone Number (_____)** _____

Policy Number _____ **Group Number** _____

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

NOUS13UB00168-01 03/13

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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 will not try to 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:

- The BMSPAF and the companies that BMSPAF uses to administer the program for free medicine (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 the 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).
- My insurance company and healthcare providers and others who may be helping me apply to this program to share information about me with the BMSPAF and its Administrators.

I understand that:

- The 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.
- The 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.
- The BMSPAF and its Administrators will only share my information as described on this form or as required or allowed by law.
- If I am enrolled, the 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 have the right to revoke my promises and permissions at any time by writing to the BMSPAF at the address in this sign-up form.
- If I revoke my promises and permissions, I will no longer be eligible for this program and my enrollment will end.
- I may not be eligible for free medicine if I have prescription coverage that will pay for my medicine (other than Medicare Part D).
- This program may be changed or stopped at any time without notice.

Patient Signature: _____ **Date:** _____

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

Patient Name_____

Product Requested:

- ☐ ABILIFY® (aripiprazole)
- ☐ BYDUREON® (exenatide extended-release for injectable suspension)
- ☐ BYETTA® (exenatide)
- ☐ ELIQUIS® (apixaban)
- ☐ KOMBIGLYZE™ XR (saxagliptin and metformin HCl extended-release)
- ☐ NULOJIX® (belatacept)
- ☐ ONGLYZA® (saxagliptin)
- ☐ ORENCIA® (abatacept)
- ☐ SymlinPen® (pramlintide acetate) Pen Injector

Ship to: ☐ Healthcare Provider ☐ Patient (available only for oral and subcutaneous (SC) injection medications)

For oral and 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 at a time for oral medications, Bydureon, and Orencia. Up to a 30 day supply is available at a time for: Byetta and SymlinPen.

For physician-administered Intravenous Infusion medications: Provide the following information for up to a 4-week supply**

Drug Name:_____ **BSA/Weight**_____ **Patient ICD-9/Diagnosis** _____

Dose(s) and Dosing Schedule/Frequency:

Scheduled Administration Dates*:**

* If you are prescribing a patient both Orencia SC and IV, please complete both the SC and physician-administered intravenous infusion sections above.
** You will need to contact the Foundation to request orders of these medications after the initial shipment is received.
*** 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 _____ **State License #** _____
Physician NPI # _____ **Physician Tax ID #** _____
Facility Name _____ **Phone** _____ **Fax** _____
Facility Address _____ **City** _____ **State** _____ **Zip** _____
Primary Contact Name _____ **Phone** _____ **Fax** _____
Primary Contact Email Address _____ **Title** _____
Preferred Method of Contact ☐ Phone Only ☐ Fax Only ☐ Phone and Fax
Shipping Address *(if different from the Facility Address noted above)* _____
Shipping Contact Name _____ **City** _____ **State** _____ **Zip** _____
State License # of the Shipping Address Location *(if different from the Facility Address noted above)* _____

I certify that treatment with this medicine for this patient is medically necessary, based on my independent clinical judgment. I authorize this prescription. I represent that any information I have provided about this patient is complete, accurate accurate. I certify that I have the authority to disclose this patient's information and have obtained, if requried by HIPAA or other applicable privacy laws, this patient's authorization for the disclosure. I understand that the BMSPAF and/or their agents are relying on this information. To the best of my knowledge, this patient has no prescription insurance coverage for the indicated medication, including Medicaid, Medicare or other public or private programs. I acknowledge and agree not to submit an insurance claim or other claim for payment to any third-party payer (private or government) for the medication. I understand that the BMSPAF reserves the right to modify or terminate this program at any time. I understand that the 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. My signature certifies that the medication received from the BMSPAF will not be resold nor offered for sale, trade or barter and will not be returned for credit. I understand that BMSPAF reserves the right to recall or discontinue product at any time without notice.

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

Please remember to include a new prescription for oral and subcutaneous injection medications.

NOUS13UB00168-01 03/13