Bristol-Myers Squibb
access|support®

Oncology Access and Reimbursement Support

1-800-861-0048 1-888-776-2370 FAX

Simple Steps to Enroll

Physician

- ☐ Complete the Services and Treatment sections on page 1
- ☐ Complete the Physician Information section on page 2
- ☐ Read, sign, and date Physician Certification on page 2
- ☐ Have the patient fill out the Financial, Drug & Medication Information section on page 3 if requesting Alternative Coverage or Support Research or Referral to Bristol-Myers Squibb Patient Assistance Foundation (BMSPAF)

Patient

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

FAX completed and signed enrollment form to BMS Access Support® at 1-888-776-2370

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

Please Note: If referred to BMSPAF, your office will receive a prescription form to complete

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
- If free product is requested from BMSPAF, you may need to send your most recent federal tax return or other proof of income upon request

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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Services–to be completed by Physician

Services Requested (Please choose all services desired.)

- ☐ **Benefit Review (BR), Prior Authorization (PA), Appeals Assistance (AA)**
- ☐ **BR, PA, AA Services Performed for New Enrollment Year**
  For a patient currently on one of the BMS medicines below. Provide BR, PA, and AA services as needed, in January.
- ☐ **BMS Oncology Co-Pay Assistance Program**
  Program only available for EMPLICITI, OPDIVO, OPDIVO + YERVOY REGIMEN, and YERVOY.
- ☐ **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).
- ☐ **Specialty Pharmacy Coordination (oral medications only)**
  Preferred Specialty Pharmacy: _____
- ☐ **Alternative Coverage or Support Research**
  (eg, independent charitable foundation referral)
- ☐ **Referral to Bristol-Myers Squibb Patient Assistance Foundation (BMSPAF)**
  BMSPAF is an independent, non-profit organization that helps eligible patients get free medication. Visit BMSPAF.org for eligibility requirements.

BMS cannot guarantee acceptance by any program or foundation.

Treatment–to be completed by Physician

Medication Prescribed

☐ OPDIVO® (nivolumab) ☐ DROXIA® (hydroxyurea) ☐ EMPLICITI™ (elotuzumab) ☐ LYSODREN® (mitotane)

☐ OPDIVO® (nivolumab) + YERVOY® (ipilimumab) REGIMEN ☐ SPRYCEL® (dasatinib) ☐ YERVOY® (ipilimumab)

Treatment Information

Patient Diagnosis: ICD Code _____ Description _____

Will This Be? ☐ Monotherapy ☐ In Combination With _____

Therapy Provided in: ☐ Physician's Office ☐ Hospital ☐ Outpatient Facility ☐ Other: _____

Is Physician in Network with Patient's Insurance? ☐ Yes ☐ No

Previous therapy given*

Dates	Dose (in mg)	Frequency

Planned therapy*

Dates	Dose (in mg)	Frequency

*Include combination medications if relevant.

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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 Certification–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, BMSPAF, and their respective agents and assignees, and I have obtained this patient's authorization for the disclosure, if required by HIPAA or other applicable privacy laws; **(3)** I have prescribed the medication to this patient based on my professional judgment of medical necessity; **(4)** If 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 third-party payer (private or government) or the patient, and I forego any appeal of any denial of insurance coverage, for medication provided by either BMS or BMSPAF for this patient, nor will I count the free medication towards this patient's true out-of-pocket costs (TrOOP); **(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 certify, if the patient enrolls in the BMS Access Support Oncology 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 and BMSPAF (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) are 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: ☐ Private/Employer-based insurance ☐ VA or military ☐ State assistance program for medication ☐ Medicaid
(please check all that apply) **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 _____

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, Drug & Medication Information–to be completed by Patient

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

Financial Information

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)* _____

Drug Allergies

Do you have any drug allergies? ☐ Yes ☐ No If yes, please specify: _____

Medications

What medications are you currently taking? _____

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

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.

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 co-pay 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:

- You 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. This Program will cover the remainder of the co-pay, up to a maximum of $25,000 per BMS medication during a calendar year. (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, 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 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 1 calendar year.
- Patients must enroll by December 31, 2017.

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. BMS also screens for patient assistance from the Bristol-Myers Squibb Patient Assistance Foundation, Inc. (the Foundation), an independent nonprofit 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 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 5 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 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)

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, 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 co-pay 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 medication 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 spending, or other health reimbursement account. If I have Medicare Part D, I will also not count any free medication I receive towards my true out-of-pocket costs (TrOOP). 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.

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 _____ 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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