

What is the Bristol-Myers Squibb Patient Assistance Foundation?

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

What medications are available from the Foundation?

ELIQUIS® (apixaban)

DAKLINZA® (daclatasvir)

NULOJIX® (belatacept)

ORENCIA® (abatacept)

Am I able to get medication free of charge?

You may be eligible to receive free medicine if:

- You are being treated with the medicine on an outpatient basis
- You live in the USA, Puerto Rico, or the U.S. Virgin Islands
- Your yearly household income is below the Foundation's limits
- 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 calendar year.
 - You can request a report from your pharmacy that shows your out-of-pocket costs for the current year and submit it with your application.

These a few of the eligibility requirements. Meeting these requirements does not guarantee you will be accepted.

How do I apply?

Complete the following form, and return it by mail or fax:

Bristol-Myers Squibb Patient Assistance Foundation

PO Box 220769 Charlotte, NC 28222-0769

Phone: 800-736-0003 8am – 8pm EST Monday - Friday

Fax : 800-736-1611

Patient and Provider Information Checklist:

PATIENTS: COMPLETE SECTION 1*:

- 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 (for oral and subcutaneous injections)

! The Foundation may request proof of income for household and out-of-pocket expenses.

***! If there is missing information, our response to your application will be delayed.**



BMS 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: <small>*Providing SSN is optional.</small>	
Date of Birth:		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Patient Address:			
City:		State:	Zip:
Home Phone:		Cell Phone: <small>*optional.</small>	Best Time to Call: <small>*optional</small>
Alternate Contact Name: <small>*optional</small>		Relationship: <small>*optional</small>	Phone: <small>*optional</small>
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)?

<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare A or B	<input type="checkbox"/> Medicare Part D
<input type="checkbox"/> VA or Military	<input type="checkbox"/> Private Insurance	<input type="checkbox"/> None
<input type="checkbox"/> State Assistance Program for Medication		<input type="checkbox"/> Other:

Insurance Name	Phone #	ID/Policy #
Primary:		
Secondary:		
Prescription Coverage:		

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

TOTAL YEARLY HOUSEHOLD INCOME: \$	OR	TOTAL MONTHLY HOUSEHOLD INCOME: \$
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- ✓ **Proof of income may be required:** Acceptable documents would be Federal Tax Return, W2, Social Security Benefits, Bank Statements
- ✓ **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 and sign the Patient Agreement and Consent

Bristol-Myers Squibb Patient Assistance Foundation (BMSPAF) 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 tell the 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 (its 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 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 1 year 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.

Print Patient Name: _____

Patient Signature: _____ **Date:** _____

**! You must
Sign & Date in
order to apply**

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

Patient Name (print): _____

Ship Medicine to:
 Healthcare Provider (provide shipping address in Section III) Patient (for oral & subcutaneous injection (SC) medicines only)

Product Requested:
 DAKLINZA®(daclatasvir) ELIQUIS®(apixaban) NULOJIX®(belatacept) ORENCIA® SC(abatacept)* ORENCIA® IV(abatacept)

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

For Daklinza, Eliquis, and Orencia SC: Please attach a new prescription for the patient named above. 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: Oral medicines: Up to a 90-day supply available. Orencia SC: Up to 30-day supply if shipped to patient/Up to 90-day supply if shipped to provider.

For Nulojix or Orencia IV: Please provide the following information for up to a 4-week supply.

If additional medication is needed after initial shipment, orders must be requested from the Foundation.

Drug Name: _____ BSA/Weight _____ Patient ICD/Diagnosis: _____

Dose(s) and Dosing Schedule/Frequency: _____

Scheduled Administration Dates*: _____

* BMSPAF may request proof of administration, including flow sheets.

SECTION III: Prescriber and Facility Information

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? <input type="checkbox"/> Yes <input type="checkbox"/> No -- Provide Shipping Address of Facility receiving medicines		
Primary Contact Name/Title:	Primary Contact Phone:	Primary Contact Fax:
Preferred Method of Contact <input type="checkbox"/> Phone Only <input type="checkbox"/> Fax Only <input type="checkbox"/> 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:** _____

Rx PLEASE INCLUDE A PRESCRIPTION for oral & SC, up to a 1-year supply. Specify # of refills needed. Up to 90-day supplies available (Orencia SC, if shipped to patient, is limited to 30-day supply).

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