Bristol Myers Squibb™
Access Support®

Oncology Access and Reimbursement Support

PHONE: 1-800-861-0048 | **FAX:** 1-888-776-2370

Patient Name: _____ **Date of Birth:** _____

PHYSICIAN

SERVICES–to be completed by Physician

Services Requested (Please choose all services desired)

- ☐ **Benefits Review, Prior Authorization, Appeals Assistance**
- ☐ **BMS Access Support Co-Pay Assistance Program**
- ☐ **Referral to BMS Patient Assistance Foundation (BMSPAF)**
  BMSPAF is an independent, nonprofit organization that helps eligible patients get free medication. Visit BMSPAF.org for eligibility requirements.
- ☐ **Benefits Review of Specialty Pharmacy**
  Preferred Specialty Pharmacy: _____
- ☐ **Alternative Coverage or Support Research**
  (eg, independent charitable foundation referral)

! *BMS cannot guarantee acceptance by any program or foundation.*

TREATMENT–to be completed by Physician

Medication Prescribed

- ☐ **DROXIA® (hydroxyurea)**
- ☐ **EMPLICITI® (elotuzumab)**
- ☐ **OPDIVO® (nivolumab)**
- ☐ **OPDIVO® (nivolumab) + YERVOY® (ipilimumab)**
- ☐ **OPDUALAG™ (nivolumab and relatlimab – rmbw)**
- ☐ **SPRYCEL® (dasatinib)**
- ☐ **YERVOY® (ipilimumab)**

Treatment Information

Patient Diagnosis - Primary ICD Code: Description:

Diagnostic Test Result (If Applicable):

Adjuvant Therapy? ☐ Yes ☐ No

Will This Be? ☐ Monotherapy ☐ In Combination With:

Therapy Provided in: ☐ Inpatient ☐ Outpatient Hospital ☐ Outpatient Physician's Office ☐ Other:
(If an oral medication, select Other and specify)

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

Previous Therapy Given*

Dates	Dose (in mg)	Therapy Given	Frequency

Planned Therapy*

Dates	Dose (in mg)	Therapy Given	Frequency

*Include combination medications if relevant.

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Patient Name: _____ **Date of Birth:** _____

PHYSICIAN

PHYSICIAN INFORMATION–to be completed by Physician

Physician Name (first and 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 Email 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.

I certify, if the patient enrolls in the BMS Access Support® Co-Pay Assistance Program for a physician-administered product, to the following:

- I have read and will comply with the Program Terms and Conditions on page 6
- 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)

PATIENT

PATIENT INFORMATION–to be completed by Patient

Personal Information

Patient Name (first and last name): ☐ Male ☐ Female Birth Date:

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

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

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

Financial Information

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

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

Household income: Yearly: $ or Monthly: $

Social Security # (optional):

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

Medications: What medications are you currently taking?

Patient Name: _____ **Date of Birth:** _____

PATIENT

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 the BMS Access Support enrollment form
- My contact information and date of birth
- Social Security number (which is voluntary)
- Professional and employment information
- Financial and income information
- Insurance information
- Health records and information, including medications
- Biometric & Genetic information, including 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 include 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 the BMS Access Support and/or Foundation programs
- Provide the BMS Access Support program services to me, including verifying my insurance benefits, researching insurance coverage options, and referring me and my caretakers to other plans, support, 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.

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 understand that BMS or the Foundation does not sell or rent personal information collected about me from this Program. I have a right to receive a copy of this authorization after I have signed it. 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 understand that certain state laws may allow for the right to request access to, or deletion of, my information. I understand that these state rights are not absolute and only apply in certain circumstances. Therefore, I acknowledge that I may not receive a response to my request to the extent required or permitted under relevant laws. I agree that I may need to provide additional information in order to verify my identity, such as a government-issued ID, before my request to receive access to, or deletion of, my information will be honored. I will not be discriminated against for exercising my rights, but I understand that I may not be able to receive Program services if I do not allow use of my information. To submit an access or deletion request, I may call 1-855-961-0474 or complete the online form at www.bms.com/dpo/us/request.

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Patient Name: _____ Date of Birth: _____

PATIENT

PATIENT AUTHORIZATION AND AGREEMENT (cont.)

6. 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.

Medication Prescribed

- ☐ DROXIA® (hydroxyurea)
- ☐ EMPLICITI® (elotuzumab)
- ☐ OPDIVO® (nivolumab)
- ☐ OPDIVO® (nivolumab) + YERVOY® (ipilimumab)
- ☐ OPDUALAG™ (nivolumab and relatlimab – rmbw)
- ☐ SPRYCEL® (dasatinib)
- ☐ YERVOY® (ipilimumab)

These are my written instructions and my permission for:

- 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 1-800-736-0003 for this information.

PATIENT INITIALS: _____

Please initial here OR send in your income documentation.
Initialing here will speed up processing time for your application and will not impact your credit score.

I HAVE READ THIS AUTHORIZATION AND AGREE TO ITS TERMS:

Print Name of Patient or Personal Representative:

Description of Personal Representative's Authority: Zip:

Preferred Email Address: Phone:

Patient Date of Birth:

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. Power of Attorney documentation is required if someone other than the patient signs. You may fax the documents to 1-888-776-2370 or call 1-800-861-0048 for further assistance.

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

[Program only available for EMPLICITI® (elotuzumab), OPDIVO® (nivolumab), OPDIVO® (nivolumab) + YERVOY® (ipilimumab), OPDUALAG™ (nivolumab and relatlimab – rmbw), & YERVOY® (ipilimumab)]

The BMS 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-pays, or co-insurance requirements.

Patient Eligibility:

- Patients must have commercial insurance, but their coverage does not cover the full cost of their prescribed Bristol Myers Squibb (BMS) medication. Co-pay assistance is not valid where the entire cost of the medication is reimbursed by insurance.
- Patients are not eligible if they participate in any state or federal healthcare program including Medicaid, Medicare, Medigap, CHAMPVA, TriCare, Veterans Affairs (VA), or Department of Defense (DoD), 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.
- Cash-paying patients are not eligible for co-pay assistance.
- Patients or their guardian must be 18 years of age or older.
- Patients must live in the United States or Puerto Rico.

Program Benefits:

- For eligible commercially insured patients, the patient may pay as little as $0 per infusion.
- This Program will cover the co-pay for each dose of a BMS medication, up to a maximum of $25,000 per BMS medication during a calendar year.
- Patients are responsible for any costs that exceed the Program's maximum of $25,000 per BMS Medication.
- 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 the date the claim was processed.
- The Program may apply retroactively to out-of-pocket expenses that occurred within 180 days prior to the date of the enrollment. These benefits are subject to 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, supply charges or other treatment costs, or any costs associated with a hospital stay.
- All Program payments are for the benefit of the patient only.

Program Timing:

- The enrollment period is 1 calendar year.

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 benefits 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.
- The Program benefits are not transferable and is limited to one (1) per patient, per medication. This offer cannot be combined with any other offer, rebate, coupon or free trial.
- 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 Program 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.

Effective November 10, 2022