Eliquis 360 Support

ELIQUIS 360 SUPPORT

Co-Pay and Patient Support Program FAQs

This FAQ has been created to help ELIQUIS field representatives answer questions about the ELIQUIS 360 Patient Support Program that frequently arise during customer visits.

The FAQ should be used as a reference tool only and must not be used during detailing or shared with customers.

This resource is internal only and must only be used as an additional training resource.

Eliquis®
(apixaban) tablets 5mg 2.5mg

Frequently Asked Questions

Free Trial Offer (FTO) Card

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Frequently Asked Questions

$10 Co-Pay Card

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Frequently Asked Questions

Patient Support Services

Glossary of Key Terms

$10 Co-Pay Card FAQs

Reminder: An FTO card must be used prior to a patient beginning use of a $10 co-pay card. Once the $10 co-pay card is utilized, a patient cannot make use of an FTO retroactively or for a future prescription.

1. Who is eligible to use the $10 co-pay card?

Patients may be eligible for the $10 co-pay card if they are insured by commercial insurance and their insurance does not cover the full cost of their ELIQUIS prescription. Patient must be 18 years of age or older and a resident of the United States, Puerto Rico, or other select U.S. Territories. Please reference eligibility requirements and terms of use on the back of the co-pay brochure or click here for ELIQUIS 360 Terms and Conditions. Eligibility needs to be reactivated every two years.

2. Are patients who are enrolled in a state exchange through the Affordable Care Act (ACA) able to use the $10 co-pay card?

Patients who receive prescription drug insurance through the ACA or health exchange are eligible to use the $10 co-pay card. Patients are not eligible if they are enrolled in any state or federally funded prescription insurance program, including but not limited to Medicare Part D, Medicaid, Medigap, Veterans Affairs (VA), or Department of Defense (DOD) programs; patients who move from commercial to state or federally funded prescription insurance will no longer be eligible. Some exchange plans may be an exception to this rule.

3. Can $10 co-pay cards be used for eligible commercial patients when their prescription drug coverage has ELIQUIS as 'Not Covered' or 'Prior Authorization Required'?

The $10 co-pay card will only work if ELIQUIS is processed as covered at the pharmacy. The $10 co-pay card will not work if ELIQUIS has a restriction at the pharmacy or with the patient's insurance. This will cause the co-pay claim to be returned as a denial. If a prior authorization (PA) is required, the PA must be completed and approved before the $10 co-pay card will work.

4. If a Medicare patient declined Part D prescription drug coverage and instead continues to receive benefits under a commercial plan, perhaps from a current or prior employer for example, then are they eligible for the $10 co-pay card?

Yes, the patient is eligible to use the $10 co-pay card because their prescription drug benefit is not in any part paid for through government-funded programs. These patients, however, need to make sure to answer the questions in the card activation process appropriately to ensure eligibility. The question asks specifically if the government pays for any part of the patient's prescription drug coverage even if the patient is over 65.

$10 Co-Pay Card FAQs - cont'd

5. Does a patient need to activate the $10 co-pay card prior to use?

Yes, the patient needs to activate their $10 co-pay card prior to use by either calling the toll-free number at 1-855-ELIQUIS, or going online to www.ELIQUIS.com. Activation and first use of the $10 co-pay card must take place by the date listed on the back of the $10 co-pay card/brochure.

5a. Can a $10 co-pay card be activated by a pharmacist?

Yes and no. The pharmacy is only allowed to enroll patients using the site that does not collect patient demographics: www.activatethecard.com/bmspharmacyportal, however it is not preferred.

It is preferred that a patient or caregiver activate a card so that ELIQUIS 360 can capture patient demographics and have direct access to patients in our program. Patients and caregivers can activate the card by either calling the toll-free number at 1-855-ELIQUIS, or going online to www.ELIQUIS.com.

6. Does the $10 co-pay card expire?

The co-pay card must be activated by the date printed on the back, and $10 co-pay eligibility will expire 24 months from the date of activation at which time patients will need to reconfirm their eligibility in order to re-enroll in the Program for another 24 months. See question #7.

Patients will be notified via a letter in the mail 3 months prior to expiration, with 3 attempts.

7. Can a patient get a new $10 co-pay card after 24 months?

Eligible patients must re-enroll after 24 months but can continue to use their existing $10 co-pay card. Patients must still meet all eligibility requirements. A letter will be sent to patients approaching the 24-month expiration directing them to call 1-855-ELIQUIS to reconfirm eligibility and re-enroll in the Program for another 24 months. If a patient does not call to reconfirm their eligibility, they will be removed from the co-pay program.

8. What is a rebate form and when is it needed? How can patients obtain a rebate form?

Some pharmacies may not accept $10 co-pay cards. A rebate form allows patients in this situation to be reimbursed after they pay for their prescription. Additionally, the rebate form can be used in the event that a patient obtains a $10 co-pay card after they have picked up and paid for their prescription. Lastly, rebate forms can be used on a mail-order prescription. In this case, a $10 co-pay would be applied for each 30-day supply. After answering a few simple questions to validate eligibility, patients can download a personalized form online at www.patientrebateonline.com based on their Card ID, Name, and Date of Birth. This form, along with a label and receipt, can be mailed back to McKesson for reimbursement. In most cases, checks are issued within 2–4 weeks of eligibility verification. If the rebate form qualifies for reimbursement, the patient will receive a reimbursement check in 2–4 weeks.

$10 Co-Pay Card FAQs - cont'd

For patients who do not have access to a computer, they can call McKesson at 1-866-279-4730 to request a rebate form and one will be mailed to them. This information is also on the back of the card.* See snapshot below.

Co-pay Card

ELIGIBILITY REQUIREMENTS:
You may be eligible for the Co-pay Card for ELIQUIS® (apixaban) if:
1. You are insured by commercial insurance and your prescription insurance coverage does not cover the full cost of your prescription, that is, you have a co-pay obligation for ELIQUIS; **2.** You do not have prescription insurance coverage through a state or federal healthcare program, including but not limited to Medicare Part D, Medicaid, Medigap, Veterans Affairs (VA), or Department of Defense (DOD) programs; patients who move from commercial plans to state or federal healthcare programs will no longer be eligible; **3.** You are 18 years of age or older; and **4.** You are a resident of the United States, Puerto Rico, or other select U.S. Territory.

TERMS OF USE:
1. Eligible patients who present an activated Co-pay Card together with a valid prescription for ELIQUIS at participating pharmacies may pay as little as $10 per 30-day supply (up to 74 tablets for the first fill and up to 60 tablets for all subsequent fills) for up to 24 months, subject to a maximum annual benefit of $6,400. Other restrictions may apply. Patient is responsible for applicable taxes, if any. **2.** Offer not applicable to co-pays of $10 or less. **3**. Patients, pharmacists, and prescribers cannot seek reimbursement, from health insurance or any third party, for any part of the benefit received by the patient through this offer. **4.** Your acceptance of this offer confirms that this offer is consistent with your insurance and that you will report the value received as may be required by your insurance provider. **5.** Card must be activated before use. Activation and first use of the Co-pay Card must take place by December 31, 2024. Card expires 24 months from activation. Upon expiration, eligible patients may re-enroll in the Co-pay Card Program. **6.** All Program payments are for the benefit of the patient only. **7.** Only valid in the United States, Puerto Rico, and other select U.S. Territories; this offer is void where restricted or prohibited by law. **8.** This offer is non-transferable, no substitutions are permissible, and offer cannot be combined with any other rebate/coupon, free trial, or similar offer for the specified prescription. **9.** The Co-pay Card may not be sold, purchased, traded, or counterfeited. Reproductions of this Co-pay Card are void. **10.** Bristol Myers Squibb and Pfizer reserve the right to rescind, revoke, or amend this offer at any time without notice. **11.** This offer is not conditioned on any past, present, or future purchase, including refills. **12.** No membership fees.

13. The Co-pay Card for ELIQUIS is not health insurance.

* **The Co-pay Card will be accepted only at participating pharmacies. For those customers using mail order or any non-participating retail pharmacy, please call 866-279-4730 to request a patient rebate form, or go to www.patientrebateonline.com to download a form. Questions can also be submitted via mail to: P.O. Box 2914 Phoenix, AZ, 85062-2914.**

BY USING THIS CARD, YOU AND YOUR PHARMACIST UNDERSTAND AND AGREE TO COMPLY WITH THESE ELIGIBILITY REQUIREMENTS AND TERMS OF USE.

To the pharmacist: For processing assistance, please call McKesson Pharmacy Support at 1-866-279-4730.
ELIQUIS® and the ELIQUIS logo are trademarks of Bristol-Myers Squibb Company.
 432-US-2101575 11/21 Printed in USA.

9. Can the $10 co-pay card be used at a mail-order pharmacy?

Typically, mail-order pharmacies do not accept $10 co-pay cards. The patient will need to check with the individual pharmacy to see whether they accept the $10 co-pay card for ELIQUIS. For those customers using mail order or any non-participating retail pharmacy, they can call McKesson at 866-279-4730 to request a patient rebate form or download their form at www.patientrebateonline.com. See previous question (#8) for more information.

10. Can the $10 co-pay card be used with a 90-day retail prescription?

Yes, the benefit is $10 per 30-day supply. Therefore, a patient with a 90-day prescription would pay a $30 co-pay for a three-month (90-day) supply subject to the annual maximum benefit amount ($6,400).

$10 Co-Pay Card FAQs - cont'd

11. Can the $10 co-pay card be used with cash-paying patients?

No, the $10 co-pay card may not be used with cash-paying patients. The $10 co-pay card may only be used with patients who have commercial insurance and who meet all other eligibility criteria. Please reference the eligibility requirements and terms of use on the back of the $10 co-pay brochure. If patients have any questions, they can call 1-855-ELIQUIS.

12. How does the point of sale work with the $10 co-pay card where patients pay up front at the pharmacy?

The $10 co-pay card must be presented at the pharmacy along with a valid ELIQUIS prescription. The $10 co-pay information is then entered at the pharmacy in the second position after the patient's prescription insurance information. If a prescription has already been run through the patient's primary insurance and is ready for pickup (eg, the prescription was sent electronically), the pharmacy can reverse the claim and re-submit using the patient's insurance as primary and the $10 co-pay card as secondary.

13. Is there a restriction on when the $10 co-pay card can be used during a patient's therapy?

The $10 co-pay card may be used at any point during a patient's therapy, whether it is for their first fill or a subsequent refill, so long as they remain eligible for the program and satisfy the eligibility requirements and terms of use.

14. Does a patient need to present the $10 co-pay card every time to receive the benefit?

No, the $10 co-pay card must be presented at the pharmacy along with a valid ELIQUIS prescription for the card's first use. The $10 co-pay information is then entered at the pharmacy. In most cases, that information is stored in the patient record at the pharmacy. If the patient were to change pharmacies to a different chain, they would need to provide the $10 co-pay card information again. If they no longer possess their $10 co-pay card, they can call 1-855-ELIQUIS for a replacement.

$10 Co-Pay Card FAQs - cont'd

15. What amount goes toward the patient's deductible when they use their $10 co-pay card?

A majority of payers allow for the out-of-pocket expenses to be applied toward the deductible, but it can vary.

See examples FOR INTERNAL REFERENCE ONLY below:

Deductible	$200.00	The amount the patient pays for covered healthcare services before their insurance plan starts to pay
Prescription Cost	$500.00	Gross cost of prescription
Payer Contribution	$375.00	Patient's insurance plan pays 75% of the gross cost of prescription
Patient Out-of-Pocket (OOP) Responsibility That Goes Toward Deductible	$125.00	This is what the patient would pay without the ELIQUIS $10 co-pay card and the amount that is applied to the deductible
Patient Pays With $10 Co-pay Card	$10	Actual cost patient pays at the pharmacy
BMS Covers (up to $6,400/calendar year)	$115.00	The difference between the OOP responsibility and what the patient actually pays

The "Patient Out-of-Pocket Responsibility" is what is applied to the deductible. In this case, $125.00 * Please note: The Free 30-Day Trial Offer Card does NOT pay down the deductible.

16. What is the annual maximum benefit for the $10 co-pay card?

The annual maximum benefit for the $10 co-pay card is $6,400 – there is no monthly cap. The difference between the OOP amount and the $10 co-pay each month counts against this annual max benefit. The patient's max benefit resets with the start of a new calendar year.

NOTE: Eligible recipients may pay as little as $10 and this is subject to eligibility requirements, terms and conditions.

FTO Card FAQs

1. Who is eligible for the Free 30-Day Trial Offer (FTO)?

Patients who are 18 years of age or older, are a resident of the United States, Puerto Rico, or other select U.S. Territory, have a valid 30-day prescription for ELIQUIS, and who have not previously filled a prescription for ELIQUIS may be eligible for the FTO. Patients must be receiving treatment with ELIQUIS for an FDA-approved indication that an HCP has planned for more than 35 days of treatment. The FTO is applicable on a VTE starter pack or a 74-pill count.

2. Does a patient need to activate the Free 30-Day Trial Offer card?

This depends on the type of card the patient receives. There is a pre-activated FTO that is given out in the hospital setting. The FTO in the retail setting does require activation. Patients can activate the FTO card by either calling the toll-free number at 1-855-ELIQUIS, or going online to www.ELIQUIS.com.

3. Can a patient use the Free 30-Day Trial Offer more than once?

No. The FTO can only be used with the patient's first 30-day ELIQUIS prescription. It can only be used **once per patient lifetime**, regardless of a new diagnosis or dosage change.

4. What happens if a patient has already filled a prescription for ELIQUIS and then tries to use the Free 30-Day Trial Offer for the first time?

The FTO would not be valid for this patient, as the offer is limited to the first 30-day ELIQUIS prescription.

5. Can a patient use the FTO for a second diagnosis once they have used an FTO for another indication? For example, if a patient used an FTO when diagnosed with NVAF, can they use another FTO if they are later diagnosed with a PE?

No, a patient may use only **one FTO per lifetime** regardless of diagnosis.

6. Can the Free 30-Day Trial Offer be used with the Medicare/Medicaid patient population?

Yes, the FTO can be used by patients with all types of insurance coverage—Commercial, Medicare/Medicaid, other government insureds, and Cash/Uninsured.

FTO Card FAQs - cont'd

7. What will a Medicare patient's out-of-pocket cost be once they have completed the Free Trial Offer?

The Medicare patient's out-of-pocket cost will be dependent on the final coverage provided by their health plan. This can be identified by a patient calling 1-855-ELIQUIS and requesting a Benefits Review. Or, the HCP can visit hcp.ELIQUIS.com and use the formulary lookup tool to get coverage information after the patient's deductible has been met.

8. What programs other than the Free 30-day Trial Offer do you have for cash-paying patients?

Patients can call 1-855-ELIQUIS to determine if they are eligible for other programs, including the BMS Patient Assistance Foundation.

9. Does the 30-day Free Trial Offer pay down a patient's annual deductible?

The FTO does NOT pay down the deductible. Only $10 co-pay goes toward a patient's deductible.

10. For those patients whose plan requires a prior authorization for ELIQUIS or if ELIQUIS is not covered, can the free trial offer still be used?

Yes, the FTO card will work whether or not a PA has been reconciled, but patients are encouraged to request a BR in order to identify if a PA, formulary, or tier exception is required. ELIQUIS 360 will send the provider a copy of the benefits review and any prior authorization and/or formulary exception forms to be completed by the provider's office.

11. Why aren't all FTO cards pre-activated?

The retail FTO cards, which require activation, are intended for use in lieu of samples. The advantage of requiring activation is that it allows us to gather patient information and see if they are eligible for any assistance. Pre-activated cards are designated for hospital setting in order to help expedite discharge.

Both FTO and $10 Co-Pay Card FAQs

1. Can a patient use the Free 30-day Trial Offer for their first fill and the $10 co-pay card for their subsequent refills for up to 24 months?

Yes, eligible patients can use the FTO for their first ELIQUIS prescription. In addition, patients who are eligible for the $10 co-pay card can use it for subsequent refills, as long as they remain eligible. The FTO card must be used first, before the copay card, otherwise the FTO card will be invalid. Activation is required for both the FTO and $10 co-pay card. Both the $10 co-pay card and FTO have their own eligibility requirements and terms of use, which are listed on the back of each card. An FTO card may only be used **once per patient's lifetime** regardless of diagnosis or dosage change.

2. If a patient gets a 90-day retail prescription, will the commercially insured patient need to have two prescriptions, one for the Free 30-day Trial Offer and one for the $10 co-pay card?

Yes, the patient will need two prescriptions. The FTO must be used with the first 30-day prescription. The $10 co-pay card can be used by eligible patients for any refills on that prescription thereafter for up to 24 months.

3. Are the $10 co-pay card and Free 30-day Trial Offer available online?

The $10 co-pay card is available to eligible patients on www.ELIQUIS.com. The FTO card is not available online. The patient must receive the FTO card from their healthcare provider and then they can activate it online. If pharmacists need processing assistance they can call McKesson Pharmacy Support at 1-866-279-4730 (telephone number is located on the backside of the cards).

4. How long does it take to activate a card and who can activate a card for a patient?

On average, it takes about 15 minutes in total to activate a card—about 5 minutes to activate the card via either automated phone system, live agent, or Internet. It will then take up to 12 minutes for the activation to process in pharmacy systems before it can be used. A patient or a family member of the patient can activate a card on behalf of and with permission from the patient.

5. What happens if the FTO and $10 co-pay cards expire at the end of the year?

Please keep in mind that the $10 co-pay and FTO Card and Brochures that expire on December 31 of the current year will still be honored beyond year-end, therefore, those cards can remain with providers and pharmacies for use.

Patient Support Services FAQs

1. Is a prescription for ELIQUIS necessary for a patient support service to be utilized?

No, a prescription is not necessary. ELIQUIS 360 will guide a patient or provider through services available and determine which steps require a prescription.

2. What does the ELIQUIS 360 Patient Support Service Program offer?

ELIQUIS 360 Support may provide BR, as well as forms for PA, formulary exception, and tier exception submission by the HCP office.

3. What is the call-flow process that occurs when a patient calls the ELIQUIS 360 support line?

When a patient calls the ELIQUIS 360 Support line, they have the opportunity to activate an FTO or $10 co-pay card, request a BR, and are offered indication-specific educational resources. In the instance that the patient expresses additional financial hardship, they are screened for other support options such as PAF and LIS.

If the patient appears to be eligible for LIS, the Patient Services representative (PSR) will provide information to the patient on how they can apply through Social Security. The PSR can provide the phone number to the Social Security office or warm transfer the patient upon request. The PSR will follow up with the patient to determine whether they have applied and received assistance.

If the patient appears to be eligible for BMS PAF, the PSR will provide the phone number and warm transfer the patient upon request. The PSR will not follow up with the patient.

4. What are the paperwork requirements for the office staff to initiate patient support services though ELIQUIS 360?

The HCP needs to complete the BR form and the patient needs to sign the Patient Authorization and Agreement (PAA) form. These forms should be faxed to 1-855-674-8134. Alternatively, the BR form can be faxed or the patient can go to www.ELIQUIS.com/sign to provide written consent for the team to start the BR. Patient Support Services can also be initiated through the ELIQUIS 360 Provider Portal by completing the online version of the BR form. A signed PAA form from the patient is required before any patient support services can be conducted by ELIQUIS 360.

Patient Support Services FAQs - cont'd

5. What are the steps in the Benefits Review (BR) process?:

1. Patient or Provider initiates a BR by completing the paperwork and providing written authorization.
    - BRs are not proactively offered to every patient. If the patient asks about their coverage for ELIQUIS, prescription costs, or expresses a financial concern, then a BR will be offered.
2. ELIQUIS 360 Benefits Verification Specialist contacts Payer to obtain patient's benefits.
3. ELIQUIS 360 Benefits Verification Specialist calls patient to explain results and also calls office to let them know Summary of Benefits is being faxed over.
    - If there are any coverage restrictions in place (such as a prior authorization, tier exception, or formulary exception), the Benefits Verification Specialist will also send those forms to the provider with the patient and provider demographic information pre-populated. Provider must complete forms and send to Payer.
        - Benefits Verification Specialist will follow up with the Payer to ensure all documentation is received and to obtain results.
        - Benefits Verification Specialist will call the patient and provider with the results.

Note: An HCP can initiate a BR on behalf of a patient using the ELIQUIS Provider Portal or by calling 855-ELIQUIS. When a BR is initiated by the provider, a signed PAA form is required. Alternatively, a patient can go to www.ELIQUIS.com/sign to provide written authorization. A licensed prescriber/ authorized representative signature is required if submitting a BR form.

6. Does ELIQUIS 360 allow Providers to simply call to find out what a patient's co-pay will be without submitting the BR form?

No, an HCP must share protected health information with ELIQUIS 360 in order to get information about a patient's insurance benefit. Therefore, a patient authorization is required. Providers should either complete the enrollment form (along with a signed PAA from the patient) or they can have the patient call 1-855-ELIQUIS to request that a BR be conducted. Written authorization will need to be provided by the patient using the PAA form.

Patient Support Services FAQs - cont'd

7. Are BRs expedited for patients in the hospital?

Yes, the BRs for patients in the hospital are expedited and turned around in an average of 4–6 hours. It is important that the "YES" box is checked next to "Is patient currently in the hospital?" and that a primary hospital contact person/phone number is provided in order to ensure the request is handled as quickly as possible. The patient will need to sign the PAA form physically or complete the e-sign process at www.ELIQUIS.com/sign.

8. Are the ELIQUIS 360 live specialists trained on answering questions on "catastrophic coverage"?

Yes, we have two types of ELIQUIS 360 live specialists 1) Patient Services Representatives (PSRs) who answer phones, record patient information, and assess what service is being requested and 2) Benefits Verification Specialists (BVSs) who are experts on reimbursement and insurance. Questions on the donut hole, deductibles, etc. would be given to our Benefits Verification Specialists to answer.

9. How should I report a customer service issue at the call center?

If your accounts report to you that they or their patients have experienced unsatisfactory service with 1-855-ELIQUIS, please provide the following information about the call to your ELIQUIS 360 Regional Point via email so that we can quickly access and review the recording and determine what occurred:

- Date
- Approximate time
- Site Name (Office or Licensed Prescriber)
- Phone number from which call was made

Note: It is important that you neither collect nor include ANY patient information. You must NOT CALL 1-855-ELIQUIS yourself.

Patient Support Services FAQs - cont'd

10. When will we have the open enrollment help line for Medicare Part D participants to help find the best Medicare plan for the upcoming year?

The time frame of Open Enrollment is decided by CMS and is typically mid-October through early December.

We offer the Healthcare Assist (HCA) Program to our patients during Open Enrollment. The Call Center can help explain which plans patients may qualify for as well as how to enroll. Healthcare Assist provides a dedicated phone line (1-844-220-5936). The line is staffed by counselors, available Monday - Friday, 8 AM to 8 PM EST. The HCA Program can also be reached through the 1-855-ELIQUIS and selecting Option 4.

HCA gets patients started with the Medicare Part D prescription enrollment process by:

- Answering questions about coverage eligibility and alternate plan options
- Offering side-by-side comparisons of plans including coverage and co-pay information for all of their prescribed medications (not just ELIQUIS). This information will be mailed to the patient within 2 weeks.
- Researching alternative coverage options as needed
- Guiding patients on how to enroll in the plan they've selected

If a patient has elected to complete a plan comparison with an HCA agent (using the plan comparison tool on Medicare.gov), ELIQUIS 360 will mail the patient a letter (within two weeks) that details the top 3 lowest cost plans discussed. The plan comparison takes into account ALL of the drugs they are taking—not just ELIQUIS. If a patient calls the line and is not taking ELIQUIS, they will still be offered the plan comparison for the drugs they are taking.

11. Can the Interactive Voice Response system (IVR) have the ability to select other languages besides English and Spanish?

At this time, the IVR is only available in English and Spanish. Please be aware, however, when customers call 1-855-ELIQUIS, the call center has the ability to bring a translator on the line for a customer who may not speak English. These translation services are available in many languages and can be offered to customers who request an insurance benefits review or need to activate a card. Customers are encouraged to call with a healthcare provider or caregiver who speaks English in order to get started.

Patient Support Services FAQs - cont'd

12. For Institutional Reps Only: What is the ELIQUIS 360 Virtual Resource Program?

The ELIQUIS Virtual Resource Program provides access to a portal via a customized URL that can be provided to your Tier 1 or Tier 2 hospital accounts that have limited or no access to physical affordability offerings. The URL allows an institution to download and print an FTO or $10 co-pay card as well as patient educational materials (NVAF or VTE patient starter guides).

It is up to each person to align with their BMS or Pfizer counterpart when completing the request form to ensure all persons who call on an account are aware that the link has been requested by a rep. Both BMS and Pfizer RBD approvals are required via signature on the virtual request form or through an approval email. Once the URL is created, and alignment amongst the Alliance Team has been reached, one member of the team will send the link to the customer champion via the approved email template with a copy to the Alliance Team for that account. Although the FTO/$10 co-pay cards have expiration dates tied to them, the offerings through the URL will not expire.

Glossary of Key Terms

Benefits Review (BR) - With a benefits review, patients can inquire whether ELIQUIS is covered by their health plan or prescription plan. The patient will be asked to provide their insurance information to the call center agent, who will then verify the coverage for ELIQUIS, including co-pay amount, formulary status, deductible, plan limitations, or prior authorization requirements, as applicable.

Prior Authorization (PA) - If a coverage restriction is identified, such as a prior authorization, the patient will be asked for their permission to contact the patient's HCP office to notify them of the PA. ELIQUIS 360 will also provide the specific forms required by the health plan for a healthcare provider to initiate the PA process. The office can then prepare and submit the form to the plan. ELIQUIS 360 will follow up directly with the health plan to monitor the status of the prior authorization and then notify the HCP following the plan's decision.

Low Income Subsidy (LIS) Referrals - If during a call to ELIQUIS 360 the patient expresses financial hardship, ELIQUIS 360 will offer to conduct a BR and will perform a high-level eligibility screen for possible LIS assistance based on the patient's household size and income. If the patient appears to be eligible, ELIQUIS 360 will give instruction on how to apply for LIS assistance.

Formulary Exception for Product Not Covered - If through the BR process it is discovered that ELIQUIS is not covered, the patient support service will follow a similar process to the PA process. A formulary exception form will be sent to the HCP office, who can then prepare and submit to the plan. The formulary exception process requests formulary coverage when a plan does not cover a medicine. ELIQUIS 360 will follow up directly with the health plan to monitor the status of the formulary exception request and then notify the HCP following the plan's decision.

Glossary of Key Terms - cont'd

Tier Exception - If through the benefit review process it is identified that ELIQUIS is being covered in a non-preferred tier, ELIQUIS 360 will follow a similar process to the PA process. A tier exception form will be sent to the HCP office who can then prepare and submit the form to the plan. ELIQUIS 360 will follow up directly with the health plan to monitor the status of the tier exception and then notify the HCP following the plan's decision.

Appeals Assistance - If a PA, formulary exception, or tier exception is denied, ELIQUIS 360 can request the health plan's process to appeal the denial. ELIQUIS 360 will provide the HCP with the necessary forms a to appeal the denial, which will then be prepared and submitted by the healthcare provider. ELIQUIS 360 will follow up directly with the health plan to monitor the status of the appeal and then notify the HCP following the plan's decision.

The HCP's office will be responsible for completing and submitting all forms. Please keep in mind that PAs and formulary exceptions submitted by the HCP office are not guaranteed to be approved by the health plan, nor are appeals guaranteed to result in reversals of plan decisions.

Representatives may not collect patient information or fill out or submit forms on behalf of the office.