

Eliquis®
(apixaban) tablets 5mg
2.5mg

ELIQUIS 360 Support Track 2.0



Program Objectives

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- ☐ Initiate a positive patient experience
- ☐ Ensure cost is not a barrier for those patients for whom the healthcare provider (HCP) has prescribed Eliquis
- ☐ Assist patients and HCPs with navigating the payer landscape
- ☐ Ensure all eligible patients can access our offers through the program
- ☐ Pull-through field sales efforts

Program Overview

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- **Reimbursement Services include:**
 - ✓ Providing a summary of the patient's benefits (called a Benefits Review "BR")
 - ✓ Providing plan-specific forms for Prior Authorizations (PAs) when needed
 - ✓ Providing general information on the appeals process as well as formulary exception requests and tier exception requests
 - ✓ Providing information on financial assistance
- **Co-Pay and Free Trial Offers (FTO)**
- **Ways to access the program**
 - ✓ By Phone 1-855-ELIQUIS (1-855-354-7847) or by Fax 1-855-674-8134
 - ✓ On-line @ www.Eliquis.com
 - ✓ Provider Portal www.eliquis360providerportal.com

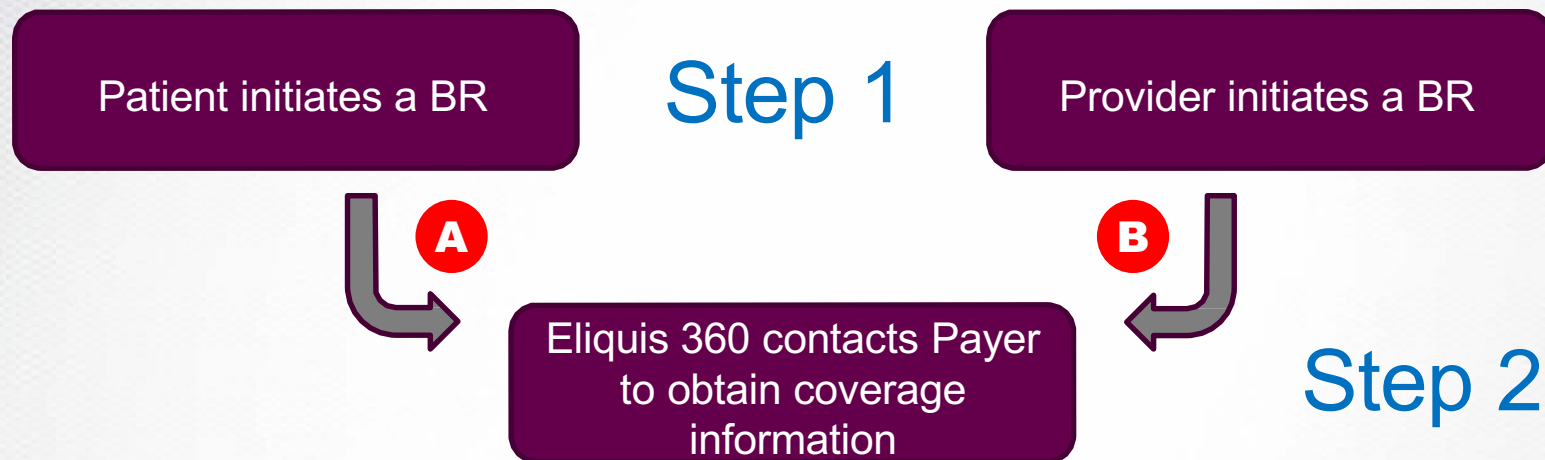
Benefits Review Process

- **Patients who are prescribed Eliquis can have a Benefits Review conducted by a live benefit verification specialist to:**
 - ✓ Confirm plan coverage
 - ✓ Payer Requirements (PA, tier exceptions, etc.)
 - ✓ Patient's estimated out of pocket cost
 - ✓ Eligibility for Eliquis Co-pay Card and/or FTO

So how do you get
this all started?

Benefits Review Process

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- **Benefits Reviews can be initiated by:**

- ✓ Patients <85%>
- ✓ Providers <15%>

Benefits Review Process

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- **Benefits Reviews typically take up to 24 business hours (Hospital initiated BRs within 4-6 hours)**

Eliquis 360 contacts Payer
to obtain coverage
information



Eliquis 360 calls the
patient/provider to review
benefits

Step 2

Step 3

Patient Driven Benefits Review (BR) Process



(Normal BR) Patient calls Eliquis 360 to activate a card (Co-pay/FTO) or to understand their coverage for Eliquis. The Eliquis 360 live specialist will offer a BR if patient requests a BR, requests coverage details, or expresses financial hardship

1. Eliquis 360 live specialist explains we need to have their signature to start the process and provides the URL to the patient/caregiver to complete the eSignature.
2. Eliquis 360 calls patient to explain results once completed.
3. If the patient would like the Summary of Benefits sent to their provider, Eliquis 360 will send

(BR with restrictions) If returned with coverage restrictions (prior authorization, tier exception, or formulary exception)

1. Eliquis 360 live specialist explains we need to have their signature to start the process and provides the URL to the patient/caregiver to complete the eSignature.
2. Eliquis 360 calls patient to explain results along with restrictions
3. If the patient would like the Summary of Benefits and plan specific forms sent to their provider, Eliquis 360 will send
4. Eliquis 360 will send plan specific forms to the provider, when available, pre-populated with provider demographic information. **Provider MUST complete forms and send to Payer.**

Provider Driven Benefits Review (BR) Process



(Normal BR) Provider initiates a BR by sending a completed Eliquis 360 enrollment form and Patient Authorization and Agreement (written PAA required)

1. If patient is present they will physically sign the PAA form
2. If patient is NOT present, the provider/site will notify patient they need to have their signature to conduct a Benefits Review and direct them to the eSign portal to capture the patient's signature on the PAA template
3. Once the PAA is signed the Benefits Review process will continue
4. Eliquis 360 calls provider to explain results and faxes Summary of Benefits

(BR with Restrictions) If returned with coverage restrictions (prior authorization, tier exception, or formulary exception)

1. (See above "Normal BR" steps 1-3)
2. Eliquis 360 calls provider to explain results and faxes Summary of Benefits along with plan specific forms, when available.
 1. Forms will be pre-populated with provider information, when possible
 2. **Provider MUST complete forms and send to Payer.**
3. Eliquis 360 will follow up with the Payer to ensure all documentation is received and to obtain results.

Patient Authorization is Required

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- All Benefits Review requests require patient authorization before Eliquis 360 can proceed with verifying patient's benefits.

The patient must physically sign the Patient Authorization and Agreement (PAA) Form

or

The patient must provide an Electronic Signature using eSign capabilities

eSign Portal: www.Eliquis.com/sign

*see following slides for detailed screen shots

Patient Authorization and Agreement Form

The patient support program for ELIQUIS (apixaban) (the "Program") is designed to provide you with reimbursement support services. To participate in the Program we will need to receive, use, and disclose your personal information. Please read this form carefully and contact Bristol Myers Squibb and Pfizer at 1-855-ELIQUIS if you have any questions. For the signed copy go to 1-855-674-8134.

What information will be used and disclosed?
My personal information will be used and disclosed, including the information on this form, my contact information, date of birth, health information and health needs, financial and income information, and insurance information.

Who will disclose, receive, and use the information?
This authorization permits my health care provider, pharmacist, health plans, and health insurers who provide services to me (my service provider) to disclose my personal information to Bristol Myers Squibb, Pfizer, and their authorized agents and assignees. Bristol Myers Squibb, Pfizer and their authorized agents may use this data in combination with other health care provider, pharmacist, health insurers, and insurance information to determine if I am eligible for, or enrolled in, another clinical program.

What is the purpose for the use and disclosure?
My personal information will be used by and shared with the service and organizations described above or plan to provide my application and provide the Program's services to me, including to verify my insurance benefits, research insurance coverage options, determine my eligibility for the ELIQUIS 360 patient support program, verify my other plans or assistance programs that may be able to help me and improve or develop the Program's services. The Program may also contact my service providers and me about the Program and the services that are available as well as contact other health care providers and health insurance organizations to determine if I'm eligible for, or enrolled in, another plan or program.

When will this authorization expire?
This authorization will be effective for 2 years unless I request earlier by text or contact at 1-855-674-8134.

Signature of Patient or Personal Representative

Signature of Personal Representative's Authority

Signature of Patient or Personal Representative

Date

When will this authorization expire?
This authorization will be effective for 2 years unless I request earlier by text or contact at 1-855-674-8134.

Eliquis 360 Support

Please sign (Eliquis 360) Support Page

Patient Authorization and Agreement Form

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What information will be used and disclosed?
My personal information will be used and disclosed, including the information on this form, my contact information, date of birth, health information and health needs (including medications, laboratory information, etc.), insurance and employment information, financial and income information, insurance information, and information about the health care provider, pharmacist, health plans, and health insurers who provide services to me (my service provider).

Who will disclose, receive, and use the information?
This authorization permits my health care provider, pharmacist, health plans, and health insurers who provide services to me (my service provider) to disclose my personal information to Bristol Myers Squibb, Pfizer, and their authorized agents and assignees. Bristol Myers Squibb, Pfizer and their authorized agents may use this data in combination with other health care provider, pharmacist, health insurers, and insurance information to determine if I am eligible for, or enrolled in, another clinical program.

What is the purpose for the use and disclosure?
My personal information will be used by and shared with the service and organizations described above or plan to provide my application and provide the Program's services to me, including to verify my insurance benefits, research insurance coverage options, determine my eligibility for the ELIQUIS 360 patient support program, verify my other plans or assistance programs that may be able to help me and improve or develop the Program's services. The Program may also contact my service providers and me about the Program and the services that are available as well as contact other health care providers and health insurance organizations to determine if I'm eligible for, or enrolled in, another plan or program.

When will this authorization expire?
This authorization will be effective for 2 years unless I request earlier by text or contact at 1-855-674-8134.

Signature of Patient or Personal Representative

Signature of Personal Representative's Authority

Signature of Patient or Personal Representative

Date

When will this authorization expire?
This authorization will be effective for 2 years unless I request earlier by text or contact at 1-855-674-8134.

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E-sign Screen Shots (1 of 6)

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BMS Eliquis 360 Support Program Patient eSignature

Please read the patient authorization and agreement form, and if you are in agreement, you may sign it electronically. Once a document is signed electronically, it will automatically be sent to the Eliquis 360 Support Program for processing. The form may be viewed by clicking on View Form, and may be reviewed and signed by clicking on Review and Sign Electronically.

Patient Authorization & Agreement Form		
Eliquis 360 Support Program English Form	Review and Sign Electronically	View Form
Eliquis 360 Support Program Spanish Form	Review and Sign Electronically	View Form



Have a question? We're here to help.

For more information, call the Eliquis 360 Support Program at 1-855-354-7847, 8 am to 8 pm, EST, Monday through Friday.

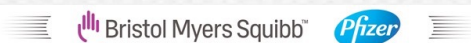
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Eliquis 360 Support

Options ▾ Please sign: Eliquis 360 Support Progr... Next Required 9

Patient Authorization and Agreement Form

The patient support program for ELIQUIS[®] (apixaban) (the "Program") is designed to provide you with reimbursement support services. To participate in the Program we will need to receive, use, and disclose your personal information. Please read this form carefully and contact Bristol-Myers Squibb ("BMS") and Pfizer at 1-855-ELIQUIS if you have any questions. Fax the signed copy to 1-855-674-8134.

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 also cancel this authorization, in whole or in part, in the future by writing to:

ELIQUIS[®] (apixaban) Reimbursement
P.O. Box 220688
Charlotte, NC 28222-0688

What information will be used and disclosed? My personal information will be used and disclosed, including the information on this form, my contact information, date-of-birth, health information and health records (including medications, biometric information, etc.), professional and employment information, financial and income information, insurance information, and information about the healthcare providers, pharmacists, health plans, and health insurers who provide services to me ("my caretakers").

Who will disclose, receive, and use the information? This authorization permits my caretakers to disclose my personal information to

Notices. I understand that once my health information has been disclosed to the Program, privacy laws may no longer restrict its use or disclosure. If I cancel this authorization, the Program will stop using or disclosing my information for the purposes listed here, except as allowed or required by law or as necessary to end my participation in the Program. I also have a right to receive a copy of this form after I have signed it. The Program agrees to use and disclose my information only for the purposes described in this authorization or as allowed or required by law. BMS does not sell or rent personal information collected about you from this Program. I further understand that I may refuse to sign this authorization and that if I refuse, my eligibility for

Start

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If for any reason you choose not to sign the document, please close your browser window.

If you have any questions, please contact BMS Eliquis 360 Support at 1-855-354-7847.
BMS Eliquis 360 Support Care Coordinators are available Monday through Friday, from 8:00 A.M. to 8:00 P.M.
For additional resources and information on BMS Eliquis 360 Support, please [click here](#) to visit BMS Eliquis 360 Support.

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E-sign Screen Shots (3 of 6)

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Please sign: Eliquis 360 Support Progr... Next Required 8

my personal information will be used by and shared with the persons and organizations described above in order to process my application and provide the Program's services to me, including to verify my insurance benefits, research insurance coverage options, determine my eligibility for the ELIQUIS co-pay assistance program, refer me to other plans or assistance programs that may be able to help me and improve or develop the Program's services. The Program may also contact my service providers and me about the Program and the services that are available as well as contact other healthcare providers and charitable organizations to determine if I'm eligible for, or enrolled in, another plan or program.

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 BMS and Pfizer will honor a request to provide access to, or deletion of, my information. BMS and Pfizer will not discriminate against me for exercising my rights, but I understand that they may not be able to provide me with Program services if they are not able to use my information. To submit an access or deletion request, I may call 855-961-0474 or complete the online form at: <<Insert URL>>.

INITIAL HERE Initials
(continued on next page)

For accompanying Full Prescribing Information, including **Boxed WARNINGS**, please visit:
http://packageinserts.bms.com/pi/pi_eliquis.pdf

Patient Authorization and Agreement Form (continued)

Patient Certifications. I certify that the personal information that I provide to the Program is true and complete. I agree that, at any time during my participation in the Program, Bristol-Myers Squibb, Pfizer and their agents

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Options ▾ Please sign: Eliquis 360 Support Progr... Next Required 0

Patient Authorization and Agreement Form (continued)

Patient Certifications. I certify that the personal information that I provide to the Program is true and complete. I agree that, at any time during my participation in the Program, Bristol-Myers Squibb, Pfizer and their agents may request additional documentation to verify my personal information. I understand that the Program may be discontinued or the rules for participation may change at any time, without notice.

I would like to enroll in the Program and have read this form and agree to its terms:

Print name of Patient or Personal Representative

Description of Personal Representative's Authority

Enter your email address **Phone Number** **Zip Code**

Email **Phone Number** **Zip Code**

SIGN HERE **Click here to sign**

Signature of Patient or Personal Representative **Patient Date of Birth** **Date**

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Eliquis 360 Support

Please sign: Eliquis 360 Support Document

Options ▾

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Next Required 3

Type Draw

Type your signature here

Close Apply

patient@email.com 1212121212 12345

Email Phone Number Zip Code

Next SIGN HERE *Click here to sign

Signature of Patient or Personal Representative Patient Date of Birth Date

↑ ↓ 2 / 2 ⊖ ⊕

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E-sign Screen Shots (5 of 6)

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Options ▾
Please sign: Eliquis 360 Support Progr...
Completed ✓

Patient Representative
Description of Personal Representative's Authority

patient@email.com
1231231234
12345

Email
Phone Number
Zip Code

SIGN HERE

Patient Sign

01/01/1900
01/01/2020

Signature of Patient or Personal Representative
Patient Date of Birth
Date

I agree to the Terms of Use and Consumer Disclosure of this document

Click to Sign

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The screenshot shows a web browser window with the 'Eliquis 360 Support' header. The main content area displays a blue checkmark icon followed by the text 'You're all set'. Below this, it says 'Thank you for signing Patient Consent Form' and 'You can also download a copy of what you just signed.' At the bottom of the main content area, it says 'POWERED BY Adobe Sign'. Below the main content area, there is a section with the text: 'If for any reason you choose not to sign the document, please close your browser window.' followed by contact information for BMS Eliquis 360 Support. At the bottom of the page, there is a footer with the Eliquis logo, a disclaimer about trademarks, and logos for Bristol-Myers Squibb and Pfizer.

Eliquis 360 Support

You're all set

Thank you for signing Patient Consent Form
You can also download a copy of what you just signed.

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If for any reason you choose not to sign the document, please close your browser window.

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Summary

Description

- Carrier that houses the BR forms and an annotated BR form card

Objective

- Educates providers about the program's support services
- Provides direction on how to get started and the steps involved in initiating a BR

Core Message

- The BR carrier is the reference guide for all who complete BRs for the patient. Written patient consent must accompany all enrollment form submissions.

Benefits Review Carrier
432US1702651-02-01



Resource: Carrier Component BR Enrollment Form and PAA

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Summary

Description

- Tear pad of 15 forms
- Form includes enrollment portion and Patient Authorization Agreement (PAA)

Objective

- Template designed for HCPs to submit BRs
- Vehicle for submitting faxed BR submission

Core Message

- The most streamlined way to initiate a BR is to have the patient call 855-ELIQUIS. If the office would like to complete this process, this enrollment form will initiate a patient's BR. The patient's signed PAA form must accompany the enrollment form on every submission.

Front

Back

Eliquis 360 Support | Benefits Review Form for ELIQUIS® (apixaban) 2.5 mg and 5 mg Tablets
Ph: 855-ELIQUIS | Fax: 855-674-8134

1. Please indicate the type of service needed ☐ Benefit Review ☐ Prior Authorization ☐ Appeals
2. Is patient currently in the hospital? ☐ Yes ☐ No
If yes, please provide primary point of contact within the hospital: Name _____ Date _____

3. Patient Information
Patient Name _____ Sex ☐ Male ☐ Female Birth Date ____/____/____
Address _____ City _____ State _____ Zip _____
Work Phone _____ Email _____
Best Time to Contact _____

4. Patient Insurance Information
Primary Insurance _____ Insurance Co. Phone _____
Cardholder _____ Relationship to Cardholder _____
Employer _____ Policy # _____ Group # _____
Prescription Drug Insurance _____ Card/ID# _____ Phone _____
Cardholder _____ Relationship to Cardholder _____

5. Provider Information
Provider Name _____ Specialty _____ Practice Name _____
Address _____ City _____ State _____ Zip _____
Office Contact _____ Phone _____ Fax _____
E-Mail _____ Title/Dx _____ UPI/BNP # _____
Primary Physician or Cardiologist _____ Phone _____ Fax _____

6. Clinical Information
Patient Diagnosis - ICD Code _____ ELIQUIS® Prescribed Dosage (mg) ☐ 2.5 mg Tablet ☐ 5 mg Tablet
☐ 12-Day Supply ☐ 30-Day Supply ☐ 90-Day Supply

7. Coverage Research (Complete this section if you would like this service)
Coverage Research provides assistance to my patient in researching alternative methods of coverage (such as Medicare Part D "Extra Help" also known as Low Income Subsidy "LIS") if ELIQUIS®.
Household Size _____ Total Yearly Combined Household Income (within 100%) _____

8. Provider Certification
I certify that, to the best of my knowledge, the information in this form is complete and accurate. I certify that I have the authority to disclose this patient's information and have obtained, if required by HIPAA or other applicable privacy law, this patient's authorization for the disclosure.
I certify that I have prescribed the product based on my professional judgment of medical necessity and for an FDA-approved use.

Signatures of patient or representative _____ Date ____/____/____
Sign HERE

Please see below to Patient Authorization. Check with Physician and Patient sign, for complete terms to 855-674-8134.
Incomplete or incorrect information may delay the process. Please ensure all information is provided correctly and signatures are obtained.
Please see accompanying US-FDA Prescribing Information, including boxed warnings and contraindications.

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Patient Authorization and Agreement Form

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My personal information will be used and disclosed, including the information on this form, my contact information, date of birth, health information and health records (including medications, biometric information, etc.), professional and employment information, financial and income information, insurance information, and information about the healthcare providers, pharmacies, health plans, and health insurers who provide services to me ("my care(s)").
Who will disclose, receive, and use the information? This authorization permits my care(s) to disclose my personal information to BMS, Pfizer, and their authorized agents and assignees. BMS, Pfizer, and their authorized agents and assignees may also share it with my care(s) and other healthcare providers, pharmacists, health insurers, and charitable organizations to determine if I am eligible for, or enrolled in, another plan or program.
What is the purpose for the use and disclosure? My personal information will be used by and shared with the persons and organizations described above in order to process my application and provide the Program's services to me. In order to verify my insurance benefits, research insurance coverage options, determine my eligibility for the ELIQUIS co-pay assistance program, refer me to other plans or assistance programs that may be able to help me and improve or develop the Program's services. The Program may also contact my service providers and me about the Program and the services that are available as well as contact other healthcare providers and charitable organizations to determine if I'm eligible for, or enrolled in, another plan or program.
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 also cancel this authorization, in whole or in part, in the future by writing to:
ELIQUIS® (apixaban) Reimbursement
P.O. Box 200588
Charlotte, NC 28222-0588
Notices: I understand that once my health information has been disclosed to the Program, my care(s) may no longer restrict its use or disclosure. If I cancel this authorization, the Program will stop using or disclosing my information for the purposes listed here, except as allowed or required by law or as necessary to end my participation in the Program. I also have a right to receive a copy of this form after I have signed it. The Program agrees to use and disclose my information only for the purposes described in this authorization or as allowed or required by law. Neither BMS nor Pfizer sell or rent personal information collected about you from this Program. 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 Program's services. 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 BMS and Pfizer may not request or address my request beyond 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 BMS and Pfizer will have a request to provide access to, or deletion of, my information. BMS or Pfizer will not discriminate against me for exercising my rights, but I understand that they may not be able to provide me with Program services if they are not able to use my information.
To submit an access or deletion request with respect to the Program, I may call 855-961-0474 or complete the online form at: www.bms.com/docu/request

The patient or his/her personal representative must be present when this form is signed.
© 2010 Bristol-Myers Squibb Company. 432US2001098-01-01 04/20 2 of 3
SIGN HERE

Patient Authorization and Agreement Form (continued)

Patient Certifications. I certify that the personal information that I provide in this form is true and complete. I agree that, at any time during my participation in the Program, Bristol Myers Squibb, Pfizer, and their agents may request additional documentation to verify my personal information. I understand that the Program may be discontinued or the rules for participation may change at any time, without notice.

I would like to enroll in the Program and have read this form and agree to its terms:

Print name of Patient or Personal Representative _____
Description of Personal Representative's Authority _____
Email _____ Phone Number _____ Zip Code _____
Signature of Patient or Personal Representative _____ Patient Date of Birth _____ Date _____

SIGN HERE

Item #: 432US2001098-01-01

432US1902166-04-01 06/20



BMS/Pfizer confidential. For internal use only. Noted for further distribution.

Resource: ELIQUIS® Co-Pay Card and Brochure*

Eliquis®
(apixaban) tablets 5mg
2.5mg

Summary

Vendor: McKesson

Distribution: field sales, www.eliquis.com, and 1-855-Eliquis

Description

- \$10 a month per 30-day supply (up to 74 tablets for first fill and 60 for subsequent fills)
 - Commercial patients
 - Cash-paying and government-insured patients are ineligible for benefit
- Annual maximum benefit of \$3,800
- Activation is required and terms of use apply
- Card expires 24 months from activation. Upon expiration, eligible patients may re-enroll
- Housed in the tiered holders

Core Message

- Eligible patients may pay as little as \$10 a month per 30-day supply for up to 24 months

*Eligibility and Terms of Use Apply

Item #: 432US1901420-02-01

432US1902166-04-01 06/20

Resource: ELIQUIS® 30-Day FTO Brochure and Card*

Eliquis®
(apixaban) tablets 5mg
2.5mg

Summary

Description

- 30-day FTO
 - Medicare D, commercial and cash patients
- Can only be used with the patient's first ELIQUIS® (apixaban) prescription
- One use per patient lifetime
- Activation is required
- In lieu of samples
- Housed in the tiered holders

Objective

- Provides an alternative to traditional samples in areas that do not accept samples

Core Message

- Eligible patients can receive a free 30-day trial of ELIQUIS®

*Eligibility and Terms of Use Apply

Eliquis®
(apixaban) tablets 5mg
2.5mg

Free 30-Day Trial Offer
Activation Required**

Free 30-Day Trial Offer*†

**ACTIVATE AT 1-855-ELIQUIS (354-7847)
OR www.ELIQUIS.com**

*Eligibility requirements and terms of use apply.
†Patient is responsible for applicable taxes, if any.

This offer is not health insurance.

Please see accompanying Full Prescribing Information,
including **Boxed WARNINGS** and Medication Guide.

RxBIN: 610524 GRP: 40026823
RxPCN: 1016 ID: 000 000 000

Eliquis®
(apixaban) tablets 5mg
2.5mg

Eliquis 360 Support

To activate the FREE 30-Day Trial Offer*†
Call 1-855-ELIQUIS (354-7847) or go to www.ELIQUIS.com

1 Activate your card (follow instructions on card).

2 Give your activated card to your pharmacist along with a valid prescription for ELIQUIS (apixaban).

3 Ask about coverage information assistance and patient support.
Our live specialists can help you understand your insurance coverage for ELIQUIS. For more information, stay on the line to speak to a live specialist, or visit www.ELIQUIS.com.

*Eligibility requirements and terms of use apply. †Patient is responsible for applicable taxes, if any.

Please see Full Prescribing Information, including **Boxed WARNINGS** and Medication Guide, in pocket.

Item #: 432US1804284-01-01

432US1902166-04-01 06/20

24/7/365 Card Activation Access

Eliquis[®]
(apixaban) tablets 5mg
2.5mg



1-855-ELIQUIS

Eliquis 360 Live Specialist

available Monday – Friday
8:00 AM to 8:00 PM EST



ELIQUIS.COM

Web Activation

24 hours a day every day



IVR

(Interactive Voice Response)

available 24 hours a day
every day

Resource: Coverage Assistance Brochure

Eliquis[®]
(apixaban) tablets 5mg
2.5mg

Summary

Description

- Brochure that outlines coverage assistance and patient education options

Objective

- Informs patients of available support services
- Housed in the tiered holder and travels with the Co-Pay and FTO cards

Core Message

- Every offer distributed should include a copy of the coverage assistance brochure



Item #: 432US1802534-01-01

Resource: ELIQUIS 360 Support Sell Sheet

Eliquis[®]
(apixaban) tablets 5mg
2.5mg

Summary

Description

- Leave-behind detailing key features of the ELIQUIS 360 Support program

Objective

- To provide physicians and their staff with a handy reference card summarizing key resources available to them and their patients

Core Message

- The HCP's "go to" guide for support phone numbers, resource links and key information regarding reimbursement programs that support ELIQUIS[®]

Eliquis 360 Support offers comprehensive programs that provide help with prescription insurance benefit reviews and case management assistance to patients.

Reimbursement Services Program for Eliquis
Access the program in three ways:

- 855-ELIQUIS and Online Support**
 - ELIQUIS 360 Support provides a dedicated phone line (1-855-ELIQUIS [354-7847]) available to patients, physicians, and staff.
 - The line is staffed by agents, available Monday - Friday, 8 AM to 8 PM EST.
 - Agents can assist with questions and matters related to benefit coverage and card activations.
- Benefit Assistance***
 - The Reimbursement Services Program for ELIQUIS can help with:
 - Patient benefit review summaries
 - Provide plan-specific form for prior authorizations when needed
 - General information on formulary exception requests and timing exception requests
 - General information on appeals process
 - For completed benefit review forms to 1-855-574-6134
 - *Health care forms are available through your ELIQUIS representative.
- Provider Portal**
 - Physicians and their staff can visit www.eliquis360providerportal.com to:
 - Track patients' prescription coverage status in real time
 - Communicate through a secure server about patient benefit review requests
 - Download and submit benefit review form on behalf of patients and upload Patient Authorization and Agreement (PAA) forms to the patient record (patients must sign the PAA form first)
 - Non reports displaying prescription coverage status of all patients by provider

Formulary Look-up Tool
Physicians and their staff can visit www.eliquisformulary.com for self-service access to local plan information including:

- ELIQUIS tier status
- Co-pay eligibility and range
- Any restrictions that may apply

Please see Full Prescribing Information, including **Boxed WARNINGS** in pocket.

Eliquis
(apixaban) tablets 5mg, 2.5mg

Additional Support

\$10 Co-pay Card*
Eliquis* (apixaban) \$10 Co-pay Card*
Eligible patients with commercial insurance who comply with the Terms of Use can pay no more than \$10 per month for a 30-day supply, for up to 24 months (after which patients can receive based on continued eligibility). Subject to a maximum annual benefit of \$3,800.

FREE 30-DAY TRIAL*
Eliquis* (apixaban) Free 30-day Trial Offer program works:
Eligible patients can receive a one-time, 30-day Free Trial Offer on their first prescription.

How the ELIQUIS \$10 Co-pay and ELIQUIS Free Trial Offer programs work:

- Patients may receive their program card when they are prescribed ELIQUIS. Co-pay cards can be accessed online at www.ELIQUIS.com.
- If eligible card activation will be required before use of either card. Patients can activate their card by visiting www.ELIQUIS.com online, or by calling 1-855-ELIQUIS Monday-Friday, 8:00 AM to 8:00 PM ET, or Saturday-Sunday, 9 AM to 6 PM ET. Activation instructions are on the card.
- The patient presents the appropriate activated card to their pharmacist, along with their prescription.
- Patients who activate the offer may receive further support from ELIQUIS 360 to better understand their coverage status for ELIQUIS.
- The ELIQUIS \$10 Co-pay card and the ELIQUIS Free Trial Offer program are not health insurance.

To find out more, VISIT www.hcp.eliquis.com OR CALL 1-855-ELIQUIS (1-855-354-7847)

Reimbursement specialists can also help with:

- Prescription insurance reviews
- Alternate coverage option information
- Information on the appeals process

Reimbursement specialists can also help locate forms for:

- Tiering exception requests
- Formulary exception requests
- Prior authorizations

Please see Full Prescribing Information, including **Boxed WARNINGS** in pocket.

Eliquis
(apixaban) tablets 5mg, 2.5mg

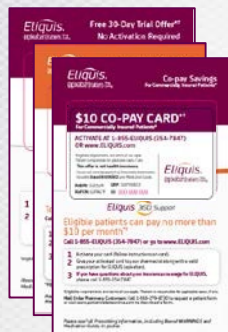
Item #: 432US1902358-01-01

432US1902166-04-01 06/20

Eliquis 360 Resources On Weborder

Eliquis®
(apixaban) tablets 5mg
2.5mg

Patient-Facing Resources



432US1901420-02-01	English Co-pay Brochure
432US1804284-01-01	English FTO Brochure
432US1804285-01-01	English Pre-activated FTO Brochure
432US1901420-03-01	Spanish Co-pay Brochure
432US1804284-07-01	Spanish FTO Brochure
432US1804285-15-01	Spanish Pre-activated FTO Brochure
432US1804285-17-01	Russian Pre-activated FTO Brochure
432US1804285-13-01	Arabic Pre-activated FTO Brochure
432US1804285-06-01	Chinese Pre-activated FTO Brochure

HCP-Facing Resources

Benefit Review Carrier

432US1702651-02-01

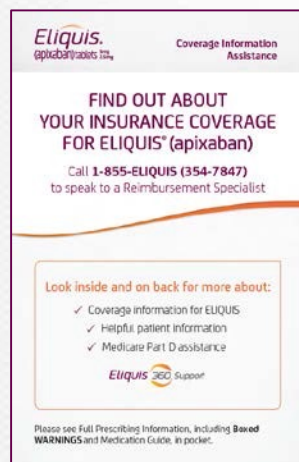


Benefit Review Fax Form Pad

432US2001098-01-01

Coverage Assistance Brochure

432US1802534-01-01



Brochure Holder

432US1603807-01-01



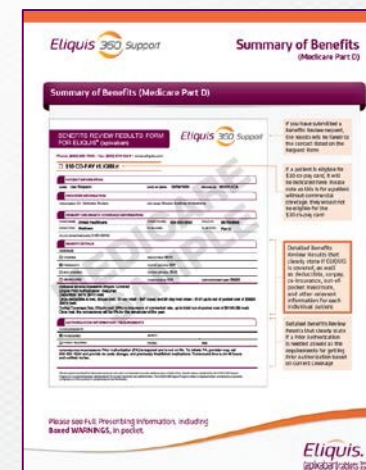
Sell Sheet

432US1902358-01-01



Summary of Benefits Sample Flashcard

432US1903842-02-01



4432US1902166-04-01 06/20

Resource: HCP Provider Portal

Eliquis®
(apixaban) tablets 5mg
2.5mg

Summary

Description

- Website that can only be accessed after registration is completed and validated

Objective

- Provides an alternative resource for offices preferring to operate in an electronic environment

Core Message

- The most efficient way to initiate a benefit review is to have patients call 855-ELIQUIS. If the office would like to submit the enrollment form on the patient's behalf, the portal is an option



www.ELIQUIS360providerportal.com

Resource: Formulary Look-up Tool

Eliquis[®]
(apixaban) tablets 5mg
2.5mg

Summary

Description

- Provides HCPs and their staff with self-service access to tier information, co-pay ranges, restrictions, etc.

Objective

- Provides the HCP with access to on-demand coverage information for patients in their area

Core Message

- 94.56% of patients nationwide with commercial or Medicare Standard Part D coverage have access to ELIQUIS[®] (based on Fingertip Formulary 6/15/2020)

The screenshot shows the Eliquis Formulary Look-up Tool website. At the top, there is a navigation bar with the Eliquis logo and links for 'U.S. FULL PRESCRIBING INFO, INCLUDING BOXED WARNINGS', 'BMS CONNECT', and 'INDICATIONS'. Below the navigation bar, there is a section titled 'INDICATIONS' which states: 'ELIQUIS is indicated to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation (NVAF)'. Below this, there is a section titled '94.56% of patients nationwide with commercial or Medicare Standard Part D coverage have access to ELIQUIS[®]'. Below this, there is a section titled 'Find ELIQUIS coverage information for your area' with a map of the United States and a search bar. The website also features a 'FORMULARY LOOKUP' button in the navigation bar.

www.EliquisFormulary.com

Summary

Description

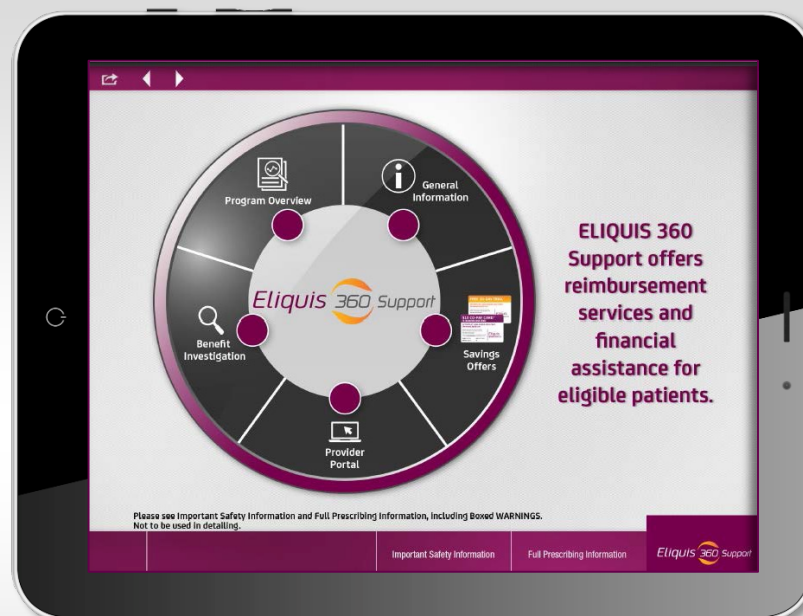
- Internally accessed interactive presentation outlining ELIQUIS 360 Support features, tools, and resources. This presentation lives on the Veeva platform for BMS and as an interactive PDF for Pfizer.

Objective

- Helps reps walk HCPs and their staff through the ELIQUIS 360 Support program. Allows the rep to easily navigate to specific program features and areas of focus.

Core Message

- ELIQUIS 360 Support is a program to help patients start and stay on treatment with ELIQUIS.



Item #: 432US1803695-03-01

Resource: ELIQUIS 360 Virtual Resource Program

Eliquis[®]
(apixaban) tablets 5mg
2.5mg

Summary

Objective:

- Support transition-of-care in institutional accounts where access to physical FTO and Co-pay cards is limited or not available
- By providing hospital specific URLs with printable:
 - Eliquis Co-pay cards
 - Eliquis Pre-activated 30-day Free Trial Offer cards
 - Patient education materials

Program Criteria:

- Account must be verified as a Tier 1 or Tier 2 Alliance Account based on the 2018 Alliance Target List
- Account must have limited or no access to physical card brochures hospital wide and there must be a significant cross department desire for access to a URL
- Senior Director or Regional Business Director approval is required from both BMS and PFE

The screenshot displays the Eliquis 360 Support website. At the top, there's a navigation bar with 'Eliquis (apixaban) tablets 5mg', 'INDICATIONS', '1/3 Click for additional indications', and 'CLOSE'. Below this, a welcome message states: 'Welcome to ELIQUIS 360 Support. To obtain a Free 30-Day Trial offer* or a \$10 Co-pay offer* for your eligible patients, click on the corresponding card below. Please provide the printed offer, including the eligibility requirements and terms of use, along with a valid prescription to your patient. Eligible patients should activate their e-copy card. Once the e-copy card has been activated, your patient can take the prescription and printed offer to their pharmacy. The Free 30-Day Trial Offer does not require activation. Your patient can take their prescription and the printed offer to their pharmacy.'

Two main offer cards are visible:

- \$10 CO-PAY CARD****
For Commercially Insured Patients*
ACTIVATE AT 1-855-ELIQUIS (354-7847)
OR www.ELIQUIS.com
- Free 30-Day Trial Offer***
NO ACTIVATION REQUIRED
For Pharmacy Benefits Information, call 1-855-ELIQUIS (354-7847)

Below the offer cards, there's a section for 'Important Safety Information' with a link to 'MORE IMPORTANT SAFETY INFORMATION'. It includes warnings about premature discontinuation of Eliquis increasing the risk of thrombotic events, and the risk of bleeding with concurrent use of aspirin, NSAIDs, or other anticoagulants.

The 'Educational Resources for Your Patients' section provides links to:

- More information on ELIQUIS
- Further education on their condition
- How to take advantage of ELIQUIS 360 savings & support

At the bottom, there are two patient education brochures:

- Getting Started on ELIQUIS**: A brochure for patients starting on Eliquis, featuring a man in a blue shirt and jeans. It includes a list of things to look for when taking Eliquis and a section on important safety information.
- Starting on ELIQUIS**: A brochure for patients starting on Eliquis, featuring a diagram of the heart and lungs. It includes a list of things to look for when taking Eliquis and a section on important safety information.

432US1902166-04-01 06/20

Resource: ELIQUIS 360 Virtual Resource Program

Eliquis[®]
(apixaban) tablets 5mg
2.5mg

Summary

Process:

- Requests should be submitted by completing the **Request Form**
- Creation of the custom link takes up to 4 weeks
- An email will be sent to all individuals on the Request Form with the custom link
- One member of the Alliance team should send the custom link to the customer champion via the **approved email template** with a copy to the Alliance Team
- **Leave Behind** – objective is for field team to share what the custom link is and that it is available within the institution (432US1902127-01-01)

ELIQUIS Virtual Resource Program
Request Form
To be completed by Alliance Integrated Account Team (IAT) member only

Account Information:
Hospital/EDN: _____
Address: _____
City: _____
State: _____
Zip: _____
Customer Champion(s): _____
Title/Role: _____
Email: _____
Phone: _____

Program Criteria:
☐ 1 - Account must be verified as a Tier 1 or Tier 2 Alliance Account based on the 2018 Alliance target list.
☐ 2 - In order to be considered, the account must have very limited or no access to physical card brochures hospital wide and there must be a significant cross department desire for access to a URL.
☐ 3 - Senior Director or Regional Business Director approval is required from both BMS & PFE, print and sign below.

Staff Approval - Print Name: _____ Signature: _____
PFE Approval - Print Name: _____ Signature: _____

Alliance IAT Members:
(The individual submitting the request form must have alignment on request across the Alliance. Alliance team members must be cc'd on submission email.)


	Name	Email
Institutional Rep/THM	_____	_____
BMS	_____	_____
PFE	_____	_____
Other	_____	_____
BMS	_____	_____
PFE	_____	_____


Next Steps:
Submit this completed form to Alliance.Marketplace@bms.com and Alliance.Kaplan@pfe.com
Once the unique URL is approved and activated, a communication will be provided to the Alliance Champion(s) and IAT members identified above.
The Alliance Champion(s) are responsible for providing the unique URL to the Customer Champion via the approved email template.


ELIQUIS
Virtual Resource Program
A WEB-BASED OPTION TO GET 360 SUPPORT

Eliquis
(apixaban) tablets 5mg
2.5mg

The Virtual Resource Program is a portal through which you can review and print the savings offers and educational resources available to your ELIQUIS patients.


PRESCRIBE
Once ELIQUIS has been prescribed for your appropriate patients, you can use the Virtual Resource Program resources.


GO
Log onto your hospital's URL, and click on the appropriate patient resources, including:
\$10 Copay Card
30-Day Free Trial Offer
Patient Education Materials


PRINT
Print the resource and accompanying Prescribing Information and give to your patients.
The affordability offer must be accompanied by a valid prescription. Each offer must be printed directly from the website.

432US1902166-04-01 06/20

Questions?

2021 E360 TBM & DBM Region Points



Region	Retail	Hospital	DBM
Northeast	Carmen Caggiano		Hamid Haider
Central East	Amy Bell	Joanna Fanning	James Egan
Greater Mid-Atlantic	Jennifer Boaz Bridgett Hill	Jen Santee	Jeff Skelton
Southeast		Rachel Forbito	Billy Woods
North Central	Marne Klinsky	Georgia Goffe	Kristen Warner
Heartland	Laura Armstrong	Teresita Harrison	Tim Hargett
West	Emilia Belotti	Mark Spalding	Brooke Stamatis

432US1902166-04-01 06/20