APPLICATION FORM

The Bristol Myers Squibb Patient Assistance Foundation, Inc., (BMSPAF) is a non-profit organization that seeks to help eligible patients get the following medicines for free:

ELIQUIS® (apixaban)
ORENCIA® (abatacept)
NULOJIX® (belatacept)
SOTYKTU™ (deucravacitinib)

If you are enrolled in the BMSPAF and need continued assistance for the medications above, you can re-apply using this form.

ELIGIBILITY

You may be eligible to receive free medicine from BMSPAF if:

- ☑ You live in the USA, Puerto Rico, or the US Virgin Islands, **and**
- ☑ You have a prescription from, and are being treated by, a doctor licensed in the US, **and**
- ☑ You are being treated with the medicine on an outpatient basis, **and**
- ☑ Your yearly household income is below the Foundation's limits, **and**
- ☑ You do not have insurance coverage for the medicine, **or** the medicine is covered by your Medicare Part D plan **and** you have spent at least 3% of your yearly household income on out-of-pocket (OOP) prescription expenses in the year for which you are seeking assistance from BMSPAF. *For example, if you are applying for assistance for 2023, please attach 2023 OOP prescription expenses to this application*.

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

Please include the following documents with your application:

- Proof of household income (such as federal tax return, social security statements)
- Photocopies of the front and back of your insurance card(s), if applicable
- Proof of out-of-pocket prescription expenses for the household (such as a pharmacy printout)

See bottom of page 2 for more information.

TO APPLY, COMPLETE THIS FORM AND:

Return it by mail to:
Bristol Myers Squibb Patient Assistance Foundation
PO Box 220769
Charlotte, NC 28222-0769

OR fax it to: 800-736-1611

Applying directly to the BMSPAF is free. There is no charge to submit your application form.

PATIENT & PRESCRIBER INFORMATION CHECKLIST:

PATIENTS: COMPLETE SECTION I

- ☐ Patient Information
- ☐ Copies of Front & Back of Insurance Cards
- ☐ Household Size & Income
- ☐ Proof of Income **OR** Initial Box on Page 3
- ☐ Out-of-Pocket Prescription Expenses
- ☐ **Sign & Date Patient Agreement & Consent**

PRESCRIBERS: COMPLETE SECTION II, III, IV

- ☐ Treatment & Prescription Information
- ☐ Prescriber & Treatment Site Information
- ☐ Shipping Address (if different)
- ☐ **Sign & Date Prescriber Certification**
- ☐ **Attach Prescription**

PLEASE NOTE: If requested information is missing from your application, our response to your application will be delayed.

Section I: Patient Information
(TO BE COMPLETED BY PATIENT. ALL BOXES ARE REQUIRED EXCEPT WHERE NOTED.)

Patient Name:		Social Security Number *(optional)*:
Date of Birth:	Gender: ☐ Female ☐ Male	
Patient Address *(no PO Boxes)*:		
City:	State:	Zip:
Home Phone:	Cell Phone *(optional)*:	Email Address *(optional)*:
Alternate Contact Name *(optional)*:	Relationship *(Required if Alternative Contact is provided)* ☐ Family Member ☐ Friend ☐ Other *If Other, please specify relationship:* _____	Alternate Contact Phone *(Required if Alternative Contact is provided)*:

Please note that an Alternate Contact may not be an individual associated with or a representative of your insurance company or their business partners.

Allergies *(Do not leave blank. If none, write "none". Attach a list on a separate page if more space is needed)*:

All Current Medications *(Do not leave blank. If none, write "none". Attach a list on a separate page if more space is needed)*:

PATIENT INSURANCE INFORMATION – Do you have insurance through any of these providers? *(Check all that apply)*

☐ Medicaid	☐ Medicare: ☐ Part A ☐ Part B ☐ Part D ☐ Part C/Medicare Advantage	
☐ VA or Military	☐ Private Insurance	☐ None
☐ State Assistance Program for Medication	☐ Other:	

INSURANCE NAME	PHONE #	ID/POLICY #
Primary:		
Secondary:		
Prescription Coverage: (*Attach a copy of both sides of your prescription insurance card*)		ID/Policy #:
		RxBIN: / RxPCN:

Number of people living in your home:
*(Include yourself, your spouse, and any dependents **currently** living with you)*

TOTAL YEARLY HOUSEHOLD INCOME: $	**OR**	TOTAL MONTHLY HOUSEHOLD INCOME:$

Proof of income may be required: Please provide your most recent federal tax return. If your federal tax return is not available, please provide as many of the following as available: W2, 1099, pension statement, Social Security statement, at least 2 consecutive pay stubs.

Medicare Part D recipients: You may be eligible for assistance if you have spent at least 3% of your annual household income on out-of-pocket (OOP) prescription expenses during the same year for which you need assistance from BMSPAF. For example, if you are applying for assistance for 2023, please attach 2023 OOP prescription expenses to this application. Your pharmacy can provide you with your year-to-date OOP expenses. Applications may not be fully processed without proof of these expenses.

Please continue to the next page to read, sign, and date the Patient Agreement & Consent.

Patient Agreement & Consent

I promise that:

All of the information I provided in my application, and other documents or information that I may provide, are complete and true. • If I am approved (enrolled), I agree that I will not be reimbursed for the free medicine from anyone else, including a prescription insurance program or any other charity. If I have Medicare Part D, I will not count any free medicine toward my true out-of-pocket costs (TrOOP). • If my insurance coverage or income changes in any way, I will immediately notify BMSPAF.

To the best of my knowledge:

My insurance plan did not require me to apply to BMSPAF and/or change or hide my insurance coverage to make me appear to be underinsured and eligible for BMSPAF. • The Alternate Contact listed on my application (if any) is not associated with or a representative of my insurance company or the insurance company's business partners.

I give my permission to:

My insurance providers, healthcare providers, and others helping me apply to this program, to share information about me with BMSPAF and the companies that BMSPAF uses to administer the program (Administrators). • My information that will be shared includes my personal information in my application, as well as my health information and records, insurance information, and financial and income information. • BMSPAF and its Administrators to use my information, and share it with my healthcare providers, my insurance company, and other organizations or companies that might be able to help me, so that BMSPAF and its Administrators may: decide if I am eligible for the program, help me get the free medicine during my enrollment (if I am eligible), and find out if I may be eligible for, or already enrolled in, another program (including a prescription insurance plan or another charitable program).

I understand that:

BMSPAF and its Administrators may contact me by phone or other methods to ask for additional information at any time, even if I am enrolled, so that they can decide if the information on my application is complete and true. • BMSPAF and its Administrators may delay, deny, or end my enrollment if my application is missing information or I do not respond to requests for documents or information. • If I am enrolled, BMSPAF will only give me free medicine for a short time, and I will have to reapply before my enrollment ends if I still need help with free medicine. •I may not be eligible for free medicine if I have insurance coverage that will pay for my medicine (other than eligible patients covered under Medicare Part D). • I understand that once my information has been disclosed, privacy laws may no longer restrict its use or disclosure. BMSPAF and its Administrators will share my information as described in this consent form or as required or allowed by law. • I may refuse to sign this consent form and if I refuse, my eligibility for health plan benefits and treatment by my healthcare providers will not change, but I will not have access to this program. • This consent will be effective for 18 months unless it expires earlier by law, or I cancel it in writing. I may cancel this consent at any time by writing to BMSPAF at the address in this application. If I cancel this consent, I will no longer be eligible for the program and my enrollment will end. • I have a right to receive a copy of this form after I have signed it. • BMSPAF may change or stop the program at any time without notice.

Print Patient Name: _____

Patient Signature: _____ **Date:** _____

You must sign and date to apply.

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 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.

Section II: Prescription - TO BE COMPLETED BY LICENSED PRESCRIBER - MD; OR NP, WHERE PERMITTED). Same person should also sign this application form.

Note: NY prescriptions must be on official NY State Prescription Form

Patient Name: | DOB:

Is the patient receiving treatment as an outpatient? ☐ Yes ☐ No

- ■ **ELIQUIS® (apixaban)**
- ☐ **ORENCIA® (abatacept) SC**
- ☐ **SOTYKTU™ (deucravacitinib)**
- ☐ **ORENCIA® (abatacept) IV***
- ☐ **NULOJIX® (belatacept)**

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

Dosage: _____

Sig: ONE TABLET TWICE A DAY

Days' Supply: ■ 90 ☐ 60 ☐ 30 ☐ Other: _____

Number of Refills: 3

Rx may be written for up to a 1-year supply (refills are subject to eligibility-period limits). Specify number of refills needed. Shipping limits: Up to a 90-day supply available.

BSA/Weight: _____

ICD-10 Code: _____

Dosage: _____

Dosing Schedule: _____

_____

Number of Doses Authorized†: _____

†Complete for up to a 4-week supply.

Section III: Prescriber Information

Name:	State License #:	NPI:
Office Name: MISSOURI HEART CENTER	Office Phone: 573-256-7700	Office Fax: 573-256-3003

Office Address *(no PO Boxes)*:	City:	State:	Zip:
1605 E BROADWAY, STE 300	COLUMBIA	MO	65201

Collaborating Physician *(if applicable)*:	Collaborating Physician NPI:

For case-related questions or fax communications, provide the preferred contact information below:

Primary Contact Name/Title:	Primary Contact Phone:	Primary Contact Fax:
	573-256-7700	573-256-3003

Preferred Method of Contact: ☐ Phone Only ■ Fax Only ☐ Phone and Fax

Section IV: Ship Medication To: *(We cannot ship to PO Boxes)*

- ■ **Patient** *(For oral / self-administered medicines only)*
- ☐ **Healthcare Provider Office** *(Office address listed in Section III)*
- ☐ **Other Treatment Site*** *(Include Treatment Site address below)*

Treatment Site Name:	Treatment Site Address *(City/State/Zip)*:	Treatment Site State License #:

Administering Physician Name *(Optional)*:	Administering Physician State License # *(Optional)*:

For Shipments to Other Treatment Sites, the state license of the treatment site is required

Prescriber Certification

I certify to the following: (1) Treatment with this medicine for this patient is medically necessary, based on my independent clinical judgment; (2) Information that I provide to BMSPAF, and in this form, is complete and accurate; (3) I have the authority to disclose this patient's information and I have obtained, if required by HIPAA or other applicable privacy laws, this patient's authorization; (4) To the best of my knowledge, this patient has no prescription insurance coverage (including Medicaid, Medicare, or other public or private programs), or is unable to afford the cost-sharing requirements associated with his/her insurance coverage for this medication, and the patient's insurance coverage for this medication, if any, does not require his/her application to BMSPAF and/or does not change or hide the patient's insurance coverage to make them appear to be underinsured and eligible for BMSPAF. (5) I will immediately notify BMSPAF if I become aware that this patient's insurance or income status has changed; (6) I will not submit an insurance claim or other claim for payment to any third-party payer (private or government), and I will forego any appeal of any denial of insurance coverage, for medication provided by BMSPAF for this patient, nor will I count the free medicine towards this patient's true out-of-pocket costs (TrOOP); (7) Any medication provided by BMSPAF for this patient will not be resold, nor offered for sale, trade or barter, or returned for credit. I understand that: (1) BMSPAF reserves the right to verify all information provided by healthcare professionals, suspend participation where inadequate information is provided, and limit enrollment based on available resources; (2) BMSPAF reserves the right to modify or terminate this program, or recall or discontinue medications, at any time without notice; (3) BMSPAF, and its agents and assignees, are relying on the certifications in this form. I authorize this prescription.

Prescriber Signature: _____ **Date:** _____

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