BRISTOL-MYERS SQUIBB PATIENT ASSISTANCE FOUNDATION, INC.
P.O. Box 1058
Somerville, NJ 08876
Phone: (800) 736-0003
Fax: (800) 736-1611

Dear Applicant,

Thank you for your interest in the Bristol-Myers Squibb Patient Assistance Foundation (BMSPAF) Program. Enclosed you will find the application form you had requested and a list of available medications.

To participate in our program, it is important that you complete all requested information and sign where indicated. Incomplete or incorrect applications will delay the application process so please ensure all information is correctly provided.

PATIENT REQUIREMENTS:

- ✓ Complete and sign Patient Information section
- ✓ Provide annual household income

HEALTHCARE PROVIDER REQUIREMENTS:

- ✓ Complete and sign Healthcare Provider Information section
- ✓ Complete the section for RX instructions; including drug name, strength and quantity per day (see drug list)
- ✓ List a shipping address of an authorized healthcare facility. Product will not be shipped to a patient's home or to a PO Box.
- ✓ Complete the ENTIRE application when requesting a change of dosage for an existing patient. Indicate "YES" on the, "change to dosing schedule" portion of the application and provide the new RX instructions
- ✓ Complete the entire application. The submission of incomplete applications will delay processing.
- ✓ Please do not attach a prescription to the application form.

SUBMIT COMPLETED APPLICATIONS BY SELECTING ONE OF FOLLOWING OPTIONS:

- ✓ MAIL: Bristol-Myers Squibb PAF, Inc.
  P.O. Box 1058
  Somerville, NJ 08876
- ✓ FAX: 1-800-736-1611 (Please DO NOT fax multiple submissions of the application)

Once your application is received, it will be reviewed and your eligibility for participation in the BMSPAF will be evaluated. You and/or your authorizing healthcare providers will be notified by mail upon completion of our review and evaluation. BMSPAF conducts periodic audits of patients' financial status, therefore you may be required to provide additional financial documentation. Please note, program rules are subject to change without notice.

If you are approved for the program, a 90-day supply of the requested medication(s) will be shipped to your healthcare provider's office. Once this initial supply of medication(s) has been used, you may be eligible for three additional 90-day refills. For your convenience, you may request product refills 60 days after your most recent order of the product(s) by calling 1-800-736-0003. It is not necessary to complete a new application during the year following your approval for participation in the BMSPAF unless there is an increase in dosage of your medication or your healthcare provider prescribes another BMSPAF medication for you. Please check with your healthcare provider prior to placing any refill requests.

If you have questions or need further assistance, please call 800-736-0003, between 9:00 AM and 6:00 PM Eastern Time, Monday through Friday.

Sincerely,
Bristol-Myers Squibb
Patient Assistance Foundation, Inc.
Enclosures

BRISTOL-MYERS SQUIBB PATIENT ASSISTANCE FOUNDATION, INC.

Individual Patient Assistance Program
P.O. Box 1058 | Somerville, NJ 08876 | Phone: (800) 736-0003 | Fax: (800) 736-1611

PATIENT INFORMATION TO BE COMPLETED BY PATIENT OR LEGAL GUARDIAN

First Name: MI: Last Name: Date of Birth: / /

Mailing Address: Apt #:

City: State: Zip Code:

Social Security Number: Gender Male/Female: Phone #: ( ) E-Mail Address:

PATIENT ELIGIBILITY INFORMATION

TOTAL ANNUAL HOUSEHOLD INCOME (Include all Income, Wages, Social Security, Pension, Disability, Interest Earned on Savings, etc.) **$** **ANNUAL**

Number of people in household:

Is patient Medicare eligible YES ☐ NO ☐

Is patient Medicaid eligible? YES ☐ NO ☐

Does patient have Medicaid, Medicare or any other public or private prescription drug coverage (not including discount cards)? ☐ YES ☐ NO

Is patient a U.S. Citizen or legal resident alien? ☐ YES ☐ NO

I attest that the above information is complete and accurate. I attest that I have no prescription insurance coverage for the indicated medication, including Medicaid, Medicare or any other public or private program, and I have insufficient financial resources to pay for the prescribed therapy. By my signature, I authorize the release of the information about me and my medical condition to the Bristol-Myers Squibb Patient Assistance Foundation (BMSPAF) and/or their agents. I authorize the BMSPAF and/or their agents to use and disclose such information for the assessment of my eligibility for and enrollment into the BMSPAF and administration of the BMSPAF, which may include contacting my insurer, public funding programs, social workers, advocacy organizations, healthcare providers, or other persons or entities the BMSPAF may deem appropriate to release all medical records or requested information bearing on my eligibility to and benefits under the program. Additionally, I agree that at any time during my enrollment, the BMSPAF may request additional documentation to authenticate the statements made on my application. The BMSPAF and/or their agents agree not to disclose any information to any third party except as authorized by me or as required by law. I understand and acknowledge that this assistance is temporary and that this program may be changed or discontinued at any time without notice.

Patient or Legal Guardian's Original Signature Required: _____ Date: _____

HEALTHCARE PROVIDER INFORMATION; TO BE COMPLETED BY THE PRESCRIBING PRACTITIONER

First Name: Last Name: Professional Designation:

DEA# (If not available, please provide copy of State License): E-Mail Address:
State License #:

Facility Name:

Shipping Address 1: (Drugs cannot be shipped to the patient or P.O. Box)

Shipping Address 2:

City: State: Zip Code:

Contact Name: Phone Number: ( ) Fax Number: ( )

Mailing Address: (If different than shipping address)

City: State: Zip Code:

DRUG INFORMATION

PLEASE REFER TO ATTACHED DRUG LIST | PLEASE INCLUDE NO MORE THAN TWO PRODUCTS PER APPLICATION | IT IS NOT NECESSARY TO ATTACH A PRESCRIPTION

Drug Name:	Strength:	Quantity Per Day:
Drug Name:	Strength:	Quantity Per Day:

Is this a change in dose schedule for an existing BMSPAF member? ☐ YES ☐ NO

I represent that all information I have provided about this patient is complete, accurate and consistent with applicable privacy laws and regulations, and I understand that the BMSPAF and/or their agents are relying on this information. To the best of my knowledge, this patient has no prescription insurance coverage for the indicated medication, including Medicaid, Medicare or other public or private programs. I acknowledge and agree not to submit an insurance claim or other claim for payment to any third-party payor (private or government) for the medication. I understand that BMSPAF reserves the right to modify or terminate this program at any time. My signature certifies that the medication received from BMSPAF will not be resold nor offered for sale, trade or barter and will not be returned for credit. I further certify that no reimbursement of the cost of product has been/will be accepted by me for any treatments where product has been/will be provided free-of-charge by BMSPAF, including any product that has already been administered to the patient and for which replacement product will be provided to me. I understand that BMSPAF reserves the right to recall or discontinue product at any time without notice.

Healthcare Provider Signature: _____ Date: _____

BRISTOL-MYERS SQUIBB PATIENT ASSISTANCE FOUNDATION, INC.

DRUG NAME	DRUG NAME	DRUG NAME
Avalide tablet 150 mg/12.5mg	K-lyte tablet eff 25 meq	Sinemet tablets 25 mg/100 mg
Avalide tablet 300 mg/12.5mg	K-lyte CL tablet eff 25 meq	Sinemet tablets 25 mg/250 mg
Avapro tablet 150 mg	K-lyte DS tablet eff 50 meq	Tequin tablets 200 mg
Avapro tablet 300 mg	Kenalog 0.1% cream 80 g topical cream .1%	Tequin tablets 400 mg
Avapro tablet 75 mg	Kenalog 0.1% lotion 60 ml topical lotion .1%	Tequin tablets Teq-Paq 400 mg
Buspar Dividose tablet 15 mg – Bottle 60	Kenalog 0.1% ointment 15 g topical ointment .1%	Ultravate topical cream .05% Tube 15 g
Buspar Dividose tablet 15 mg – Bottle 180	Kenalog 0.1% ointment 60 g topical ointment .1%	Ultravate topical cream .05% Jar 50 g
Cefzil oral suspension 125 mg/5 ml	Kenalog 0.5% cream 20 g topical cream .1%	Ultravate topical ointment .05% Tube 15 g
Cefzil oral suspension 250 mg/5 ml	Kenalog aerosol topical aerosol spray .1%	Ultravate topical ointment .05% Jar 50 g
Cefzil tablet 250 mg	Kenalog 10, 5 ml vial vial 10 mg/ml	Vasodilan tablet 10 mg
Cefzil tablet 500 mg	Kenalog 40, 10 ml vial vial 40 mg/ml	Vasodilan tablet 20 mg
Coumadin tablet 4 mg	Kenalog 40, 1 ml vial vial 40 mg/ml	
Coumadin tablet 7.5 mg	Kenalog 40, 5 ml vial vial 40 mg/ml	
Coumadin tablet 6 mg	Lac-Hydrin topical cream 12%	
Coumadin tablet 3 mg	Lodosyn tablet 25 mg	
Coumadin tablet 2.5 mg	Metaglip 2.5 mg/250 mg	
Coumadin tablet 10 mg	Metaglip 2.5 mg/500 mg	
Coumadin tablet 5 mg	Metaglip 5.0 mg/500 mg	
Coumadin tablet 1 mg	Monopril tablet 10mg	
Coumadin tablet 2 mg	Monopril tablet 20mg	
Dovonex topical cream .005%	Monopril tablet 40mg	
Dovonex topical solution .005%	Plavix tablet 75 mg	
Dovonex topical ointment .005%	Pravachol tablet 10 mg	
Glucophage tablet 500 mg	Pravachol tablet 20 mg	
Glucophage tablet 850 mg	Pravachol tablet 40 mg	
Glucophage tablet 1000 mg	Pravachol tablet 80 mg	
Glucophage XR tablet 500 mg	Pronestyl capsule 250 mg	
Glucophage XR tablet 750 mg	Pronestyl tablet 375 mg	
Glucovance tablet 1.25 mg/250 mg	Pronestyl tablet 500 mg	
Glucovance tablet 2.5 mg/500 mg	Pronestyl SR tablet 500 mg	
Glucovance tablet 5 mg/500 mg	Sinemet tablets 10 mg/100 mg	