Dear Applicant,

Thank you for your interest in the Bristol-Myers Squibb Patient Assistance Foundation (BMSPAF) NULOJIX® (belatacept) Patient Assistance Program. Enclosed you will find the application form you had requested.

To participate in our program, you must be living in the U.S., Puerto Rico or the U.S. Virgin Islands and you must not have prescription drug coverage or receive any benefits that help you pay for prescription drugs, such as: Medicaid, Medicare Part D, State sponsored prescription drug programs, employee, military, retirement, or pension program drug coverage. Please note that pharmacy discount cards or drug company patient assistance programs are not considered to be prescription drug coverage and if you participate in these programs you still may qualify for assistance.

It is important that you complete all requested information and sign where indicated. Incomplete applications will be returned.

PATIENT REQUIREMENTS:
- Complete and sign the Patient Information section.
- Attach a photocopy of the ANNUAL household income (Federal tax form (1040), social security income (SSA 1099), pensions, interest, child support).

INCOME ELIGIBILITY CRITERIA REQUIREMENTS:
- Total annual household Adjusted Gross Income must not exceed $75,000.

HEALTHCARE PROVIDER REQUIREMENTS:
- Complete and sign the Healthcare Provider Information section. There is no need to include a prescription.
- Provide your State License Number in order to process the application.
- Include ALL product information, including product name, dose/strength, frequency, and planned treatment dates. If patient is re-applying to the program, or requesting a refill, the application must include the date(s) of treatment given since the last shipment received through this program.
- List a shipping address of an authorized healthcare facility. Product will not be shipped to a patient’s home or to a P.O. Box.
- Complete the ENTIRE application.

SUBMIT COMPLETED APPLICATION BY SELECTING ONE OF THE FOLLOWING OPTIONS:
- MAIL: BMSPAF NULOJIX® (belatacept) Patient Assistance Program
  P.O. Box 991
  Somerville, NJ 08876
- FAX: (866) 694-2545 (Please DO NOT fax multiple submissions of the application.)

You will be notified by mail upon completion of our review and evaluation. Please note that program rules are subject to change without notice. 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.
Enclosure
BRISTOL-MYERS SQUIBB PATIENT ASSISTANCE FOUNDATION, INC.
NULOJIX® (BELATACEPT) PATIENT ASSISTANCE PROGRAM
P.O. Box 991 | Somerville, NJ 08876 | Phone: (800) 736-0003 | Fax: (866) 694-2545

PATIENT INFORMATION TO BE COMPLETED BY PATIENT OR LEGAL GUARDIAN

<table>
<thead>
<tr>
<th>First Name:</th>
<th>MI:</th>
<th>Last Name:</th>
<th>Date of Birth:</th>
<th>City:</th>
<th>State:</th>
<th>Zip Code:</th>
</tr>
</thead>
</table>

Street Address where you live:  
Mailing Address (if different from above):  
Social Security Number:  
Gender: Male  Female  
Phone number:  

PATIENT ELIGIBILITY INFORMATION - ATTACH PROOF OF ANNUAL HOUSEHOLD INCOME (REQUIRED)

TOTAL ANNUAL HOUSEHOLD INCOME (include all Annual Income, Wages, Social Security, Pensions, Interest Earned on Savings, Disability, Child Support, etc.): $  
* If you have indicated no income ($0), your application may be subject to audit or request for additional documentation.

Do you have any public or private prescription drug coverage or are you in any benefit program that helps you pay for your Prescription Drugs? Yes  No

Patient Signature: ___________________  Date: _______________________  

HEALTHCARE PROVIDER INFORMATION TO BE COMPLETED BY THE PRESCRIBING PRACTITIONER

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Last Name:</th>
<th>Shipping Address, if different from mailing address</th>
<th>Healthcare Provider</th>
<th>Infusion Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>State License Number:</td>
<td>NPI Number:</td>
<td>Facility Name:</td>
<td>Facility Name:</td>
<td>Shipping Address:</td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
<td>Zip Code:</td>
<td>City:</td>
<td>State:</td>
</tr>
</tbody>
</table>

Contact Name:  
Contact Phone:  
Contact Fax:  

Diagnosis (ICD-9 Code):  
PRODUCT REQUESTED  
NULOJIX Initial Treatments (10 mg/kg)  
NULOJIX Maintenance Treatment (5 mg/kg)  

DOSE (mg or unit)  FREQUENCY  PLANNED OUTPATIENT TREATMENT DATE(S)  
Days: 15, 29, 57 and/or 85  

COMPLETE THIS SECTION ONLY IF RE-APPLYING TO PROGRAM

<table>
<thead>
<tr>
<th>PRODUCT ADMINISTERED</th>
<th>DOSE (mg or unit)</th>
<th>FREQUENCY</th>
<th>PREVIOUS TREATMENT DATE(S) (from flow sheets)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>NULOJIX</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Infusion Flow Sheets of previous treatments may be requested for auditing purpose, as a proof of administration of the product received through the BMSPAF NULOJIX Patient Assistance Program.

I represent that any 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 understand that BMSPAF reserves the right to recall or discontinue product at any time without notice.

Healthcare Provider Signature: ________________________  Date: ________________________  

Revised 6/27/2011