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.

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 provided is correct.

PATIENT REQUIREMENTS:

- ✓ Complete and sign the Patient Information section
- ✓ Attach a photocopy of the ANNUAL household income. (Federal tax form (1040), Request for Transcript of Tax Return (Verification of non-filing form 4506-T), social security income (SSA 1099), pensions, interest, retirement, child support, letter from healthcare professional, shelter or patient advocate, Healthcare Provider (clinic, shelter etc.) income pre-certification statement).

HEALTHCARE PROVIDER REQUIREMENTS:

- ✓ Complete and sign the Healthcare Provider Information section
- ✓ Please provide DEA# or copy of State License.
- ✓ Complete the section for RX instructions; including drug name, strength and quantity per day
- ✓ 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.
- ✓ Please do not attach a prescription to the application form.
- ✓ Complete the ENTIRE application, including when only 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 prescription instructions.

SUBMIT COMPLETED APPLICATIONS BY SELECTING ONE OF THE 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 provider will be notified by mail upon completion of our review and evaluation. 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 1-800-736-0003, 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.

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

Bristol-Myers Squibb LifeLines OF CARE PATIENT ASSISTANCE FOUNDATION

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 #: ( )

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

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 currently enrolled in a Medicare Part D Prescription Drug Plan **Yes** ☐ **No** ☐

Does patient have public or private prescription drug coverage (not including discount cards)? **Yes** ☐ **No** ☐

Is patient a U.S. Citizen or legal resident alien? **Yes** ☐ **No** ☐

Did you file a Federal Tax Return for the most current tax year? **Yes** ☐ **No** ☐

If no, you must sign below to agree that you are asking the IRS to send confirmation to the Bristol-Myers Squibb Patient Assistance Foundation to confirm that you did not file a Federal tax return for the previous tax year.

Patient Signature for Application: _____ **Date** _____

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# (Required):
State License # (Please provide copy of State License):

Facility Name:

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

City: State: Zip Code:

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

Mailing Address: (If different than shipping address)

City: State: Zip Code:

PLEASE INCLUDE NO MORE THAN THREE PRODUCTS PER APPLICATION | IT IS NOT NECESSARY TO ATTACH A PRESCRIPTION

Drug Name:	Strength:	Quantity Per Day:
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: _____