Bristol Myers Squibb® Access Support®

Enrollment Form

FAX: 1-888-776-2370
PHONE: 1-800-861-0048
E-ENROLL: BMSeSign.com/hcp
HCP PORTAL: MyBMSCases.com

PATIENT INFORMATION:

› *Patients will need to sign the Patient Authorization & Agreement on page 4 in order to submit this form. If any information or patient signature is missing, it may cause delays.*

*** REQUIRED FIELD**

*** First Name:** _____ MI: ____ *** Last Name:** _____ *** Date of Birth:** ____/____/____ *** Gender:** Male ☐ Female ☐

*** Address:** _____ *** City:** _____ *** State:** _____ *** ZIP:** _____

*** Phone:** _____ Email: _____ Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Alternate Contact Name: _____ Relationship: _____ Alt Phone: _____

› *Alternate Contact may not be an individual associated with or a representative of patient's insurance company or their business partners.*

TREATMENT INFORMATION: *To be completed by the Healthcare Provider*

HCP-ADMINISTERED THERAPY

☐ **OPDIVO®** (nivolumab)† injection, for intravenous use

☐ **OPDIVO Qvantig™** (nivolumab and hyaluronidase-nvhy)† injection, for subcutaneous use

☐ **OPDIVO®** (nivolumab)† + **YERVOY®** (ipilimumab)

†For dual benefits review or for patients transitioning from intravenous to subcutaneous, select **Dual Benefits Review** in ***Services Requested*** section below.

☐ **OPDUALAG™** (nivolumab and relatlimab-rmbw)

☐ **ABRAXANE®** (paclitaxel protein-bound particles for injectable suspension) (albumin-bound)

☐ **EMPLICITI®** (elotuzumab)

☐ **ISTODAX®** (romidepsin)

☐ **REBLOZYL®** (luspatercept-aamt)

☐ **VIDAZA®** (azacitidine)

☐ **YERVOY®** (ipilimumab)

ORAL THERAPY

☐ **AUGTYRO®** (repotrectinib)‡

☐ **IDHIFA®** (enasidenib)

☐ **INREBIC®** (fedratinib)

☐ **KRAZATI®** (adagrasib)‡

☐ **ONUREG®** (azacitidine)

☐ **POMALYST®** (pomalidomide)

☐ **REVLIMID®** (lenalidomide)

☐ **SPRYCEL®** (dasatinib)

☐ **THALOMID®** (thalidomide)

☐ **ZENBEXUS™** (iberdomide)‡

‡*For Free Trial Offer and Bridge Program, see page 6.*

*** Medications dispensed through:** ☐ Buy and Bill ☐ Specialty Pharmacy ☐ In-Office Dispensing Pharmacy

*** HCP-administered treatment to be administered in:** ☐ Physician's Office ☐ Outpatient ☐ Other: _____

Dosing: _____ *** Primary Diagnosis Code:** _____ Description: _____

Is the BMS medication being used in combination with another product/therapy? ☐ Yes ☐ No

List medications to be used in combination with BMS therapy: _____

Line of Therapy: ☐ First ☐ Second ☐ Third+ Treatment Setting: ☐ Neo-Adjuvant ☐ Adjuvant

*** Has the patient started therapy?** ☐ Yes ☐ No Date of Treatment: ____/____/_____

Previous Treatment: ☐ None ☐ Surgery ☐ Radiation ☐ Chemotherapy (please specify): _____

REQUIRED FOR OPDIVO, OPDIVO QVANTIG, OPDIVO + YERVOY, AND OPDUALAG ONLY:

Primary Tumor Type: _____ Histology: _____ Stage: _____

Biomarker Test Result ☐ PD-L1 ☐ EGFR or ALK ☐ dMMR/MSI- ☐ N/A ☐ Other: _____

SERVICES REQUESTED (Check all that apply): *To be completed by the Healthcare Provider*

☐ **Benefits Review, Prior Authorization, Appeals Assistance**

☐ **Dual Benefits Review** Available only for OPDIVO and OPDIVO Qvantig. See ***Treatment Information*** section above.

☐ **BMS Access Support Co-Pay Assistance Program**§ For program Terms and Conditions, visit www.BMSAccessSupport.com/co-pay-financial-assistance

§*Not available for VIDAZA or ISTODAX.*

☐ **Free Trial Offer, Commercial Bridge Program, Specialty Pharmacy Rx** Available only for AUGTYRO, KRAZATI, or ZENBEXUS. Prescription required. See page 6. For Terms and Conditions, **please click here**.

☐ **Alternative Coverage or Support Research** (eg, independent charitable foundation referral)

☐ **Referral to BMS Patient Assistance Foundation (BMSPAF)** BMSPAF is an independent, nonprofit organization that helps eligible patients get free medication. Visit **BMSPAF.org** for eligibility requirements.
› *BMS cannot guarantee acceptance by any program or foundation.*

PATIENT NAME: _____ **PATIENT DATE OF BIRTH:** ____ /____ /____

INSURANCE INFORMATION:

› *Please complete all fields that apply. Remember to include a copy of the front and back of patient's insurance card for each type of insurance.*

*** Patient Has Insurance:** ☐ Yes ☐ No Is PA on file? ☐ Yes ☐ No Auth # _____

*** Insurance Type:** ☐ Private/Employer Sponsored ☐ Medicare ☐ Medicaid ☐ Other (eg, VA, TRICARE) _____

If Medicare: ☐ Part A ☐ Part B ☐ Part D ☐ Medicare Advantage

	* PRIMARY INSURANCE	SECONDARY INSURANCE	PRESCRIPTION (PBM) INSURANCE
Plan Name / State	*		
Plan Phone #	*		
Policy ID #	*		
Group Number	*		
Other Policy Holder *(if not patient)*			
Other Policy Holder Relationship to Patient			
Other Policy Holder Date of Birth			

› *Once you have completed this page, please proceed to the Patient Authorization and Agreement on pages 3-4.*

FINANCIAL INFORMATION: ›Required if Alternate Coverage or Support Research or Referral to BMSPAF is requested.

Number of people in your household (include yourself, your spouse, and your dependents): _____ *Household Income: Yearly $* _____ *or Monthly $* _____

PRESCRIBER INFORMATION: *To be completed by the Healthcare Provider*

Is physician in network with patient's insurance? ☐ Yes ☐ No

*** Physician First Name:** _____ *** Last Name:** _____

*** Physician NPI #:** _____ *** Prescriber Tax ID:** _____

*** State License #:** _____ State Medicaid #: _____

*** Facility Name:** _____ *** Phone:** _____ *** Fax:** _____

Facility Tax ID #: _____ *** Group NPI #:** _____

*** Address:** _____ Suite: _____

*** City:** _____ *** State:** _____ *** ZIP:** _____

*** Office Contact Name:** _____ Title: _____

Email: _____ *** Phone:** _____

PATIENT AUTHORIZATION AND AGREEMENT: *To be completed by the Patient.*

The BMS Access Support® program is a support program by Bristol-Myers Squibb Company ("BMS") that helps patients understand their insurance coverage and financial support options for BMS medications, such as co-pay and free medication assistance.

BMS also screens for patient assistance from the Bristol Myers Squibb Patient Assistance Foundation, Inc. ("the Foundation"), an independent nonprofit that provides free medication to qualifying patients. To participate in the BMS Access Support program or to apply for the Foundation program, these programs will need to receive, use, and disclose your personal information. Please read this authorization for BMS and the Foundation carefully and contact BMS at 1-800-861-0048 if you have any questions. Once you have read and agreed to this form, fax your signed copy to 1-888-776-2370.

1. What information will be used and disclosed?

My personal information will be disclosed, including:

- Information on the BMS Access Support enrollment form
- My contact information and date of birth
- Social Security number (which is voluntary)
- Professional and employment information
- Financial and income information
- Insurance information
- Health records and information, including medications
- Biometric & Genetic information, including tests that identify the kind of illness that I have and/or medication indicated for my treatment

2. Who will disclose, receive, and use the information?

This authorization permits my caretakers, which include my healthcare providers, pharmacists, health plans, and health insurers who provide services to me, as well as other people that I say can help me apply, to disclose my personal information to BMS, the Foundation, and their authorized agents and assignees (their "Administrators"). BMS and the Foundation and their Administrators may also share my information with my caretakers and with other healthcare providers, pharmacists, health insurers, and charitable organizations to determine if I am eligible for, or enrolled in, another plan or program.

3. What is the purpose for the use and disclosure?

My personal information will be used by and shared with the persons and organizations described in this authorization in order to:

- Process my application for the BMS Access Support and/or Foundation programs
- Provide the BMS Access Support program services to me, including verifying my insurance benefits, researching insurance coverage options, and referring me and my caretakers to other plans, support, or assistance programs that may be able to help me
- Provide co-pay assistance to me, if I am eligible
- Contact my caretakers and me about the programs and the services that are available
- Contact other healthcare providers and charitable organizations to determine if I am eligible for, or enrolled in, another plan or program
- Provide me with free medication through BMS or the Foundation, if I qualify
- Improve or develop the programs' services and other internal business purposes including analytics
- Provide me with other information and offers that BMS believes may be of interest to me including information about my medication, refill reminders, surveys, and alerts
- BMS also may use my health information to combine it with other information BMS may collect about me and my treatment and use it for the purposes described above

4. 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 cancel this authorization for either or both programs by writing to: BMS Access Support, P.O. Box 221509 Charlotte, NC 28222-1509

If I cancel this authorization for a program, I will no longer be able to participate in that program. That program will stop using or disclosing my information for the purposes listed in this authorization, except as necessary to end my participation or as required or allowed by law.

I understand that if I receive free medication for more than a year, I must reapply at least every year, sign an authorization for both BMS Access Support and the Foundation, and be accepted.

5. Notices:

I understand that once my health information has been disclosed, privacy laws may no longer restrict its use or disclosure. BMS, the Foundation, and their Administrators agree to use and disclose my information only for the purposes described in this authorization or as allowed or required by law. I understand that BMS or the Foundation does not sell or rent personal information collected about me from this Program. I have a right to receive a copy of this authorization after I have signed it. 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 BMS Access Support® or Foundation programs. 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 I may not receive a response to my request to 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 my request to receive access to, or deletion of, my information will be honored. I will not be discriminated against for exercising my rights, but I understand that I may not be able to receive Program services if I do not allow use of my information. To submit an access or deletion request, I may call 1-855-961-0474 or complete the online form at **www.bms.com/dpo/us/request**.

(continued)

PATIENT AUTHORIZATION AND AGREEMENT cont.

6. Patient certifications:

I certify that the personal information that I provide to BMS and the Foundation is true and complete. I agree that, at any time during my participation in either or both programs, BMS (and the Foundation, if applicable) may request additional documentation to verify my personal information. If there is missing information or I do not respond to requests for additional documents, my participation may be delayed, or I may no longer be able to participate. If I qualify for, and receive, co-pay assistance or free medication assistance from BMS, I agree to comply with BMS' program rules and I will not get reimbursed for the assistance I receive from anyone else, including from an insurance program, another charity, or from a health savings, flexible spending, or other health reimbursement account. I understand that assistance may be temporary and that I may be required to apply every year. I will contact BMS Access Support at 1-800-861-0048 if my insurance or treatment changes in any way. If I qualify for and receive free medication from the Foundation program, I agree to comply with the Foundation's program rules; and I will not get reimbursed for the assistance I receive from anyone else, including from an insurance program, another charity, or from a health savings, flexible spending, or other health reimbursement account. If I have Medicare Part D, I will also not count any free medication I receive towards my true out-of-pocket costs (TrOOP). I understand that the Foundation's help is temporary, I must reapply every year, and I may not be eligible if I have prescription drug coverage that will pay for my medication. To the best of my knowledge, (1) My insurance plan did not require me to apply to the Foundation and/or change or hide my insurance coverage to make me appear to be underinsured and eligible for the Foundation; (2) 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 agree to immediately contact the Foundation at 1-800-736-0003 if my insurance, treatment, or financial situation changes in any way. I understand that the BMS Access Support and the Foundation programs may be discontinued or the rules for participation may change at any time, without notice.

*Patients may complete the Patient Authorization and Agreement electronically by visiting **bmsesign.com** or by scanning the QR code here with a phone or tablet. You may also fax the documents to 1-888-776-2370 or call 1-800-861-0048 for further assistance.*

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 1-800-736-0003 for this information.

Patient Initials:_____ **PLEASE INITIAL HERE OR SEND IN YOUR INCOME DOCUMENTATION.**
Initialing here will speed up the processing time for your application and not impact your credit score.

I HAVE READ THIS AUTHORIZATION AND AGREE TO ITS TERMS:

*** Patient Name:** _____ *** Patient Date of Birth:** ____/____/____

*** Patient Address:** _____

*** Phone:** _____ Preferred Email Address: _____

Name of Personal Representative:_____

PATIENT OR PERSONAL REPRESENTATIVE SIGNATURE _____ Date:_____

If signed by the patient's representative, please indicate below the authority to act on behalf of the patient:

☐ Court Appointed ☐ Guardian ☐ Power of Attorney (must have authority to make healthcare decisions) ☐ Other

The patient or his/her personal representative must be provided with a copy of this form after it has been signed.
Power of Attorney documentation is required if someone other than the patient signs.

PATIENT NAME: _____ **PATIENT DATE OF BIRTH:** _____ /_____ /_____

PHYSICIAN CERTIFICATION: *To be completed by the Healthcare Provider*

I certify to the following:

1. To the best of my knowledge, the patient and physician information in this form is complete and accurate;
2. I have the authority to disclose this patient's information to BMS, BMSPAF, and their respective agents and assignees, and I have obtained this patient's authorization for the disclosure, if required by HIPAA or other applicable privacy laws;
3. I have prescribed the medication to this patient based on my professional judgment of medical necessity;
4. If patient receives medication from BMSPAF, 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 my patient is enrolled in BMSPAF and I become aware that his/her insurance, treatment, or income status has changed;
6. I will not submit an insurance claim or other claim for payment to anyone else, including third-party payer (private or government) or the patient, for free medication provided to the patient, and I forego any appeal of any denial of insurance coverage, for free medication provided by either BMS or BMSPAF for this patient, nor will I count the free medication towards this patient's true out-of-pocket costs (TrOOP); and
7. Any medication provided by either BMS or BMSPAF for this patient will be used only for this patient and will not be resold, nor offered for sale, trade, or barter, or returned for credit.

I certify, if the patient enrolls in the BMS Access Support® Co-Pay Assistance Program for a physician-administered product, to the following:

- I have read and will comply with the **Program Terms and Conditions**
- To the best of my knowledge, this patient satisfies the Patient Eligibility requirements, and I will notify the Program immediately if the patient's insurance status changes
- To the best of my knowledge, participation in this Program is not inconsistent with any contract or arrangement with any third-party payer to which this office/site will submit a bill or claim for reimbursement for the covered BMS medication(s) administered to the patient
- The bill or claim that this office/site will submit to the insurer or patient for payment for BMS medication(s) will have the BMS medication(s) listed separately from any bill or claim for drug administration or any other items or services provided to the patient
- I will not submit an insurance claim or other claim for payment to any third-party payer (private or government) for the amount of assistance that my patient receives from the Program
- If this office/site receives payment directly from the Program for this patient, the office/site will not accept payment from the patient for the amount received from the Program

I understand that BMS and BMSPAF

1. May verify all information provided, and not allow or suspend participation if inadequate information is received;
2. may modify, limit, or terminate these programs, or recall or discontinue medications, at any time without notice; and
3. are relying on these certifications.

SIGNATURE _____ Date:_____/_____/_____

Physician or Licensed Prescriber Signature (required—no stamps)

PRESCRIPTION INFORMATION FOR AUGTYRO® (repotrectinib) and KRAZATI® (adagrasib) *only*:

- A new prescription is required for patients referred to BMS Patient Assistance Foundation.
- AUGTYRO and KRAZATI prescriptions are only accepted via fax or through the **MyBMSCases.com** provider portal.

*** Patient Name:** _____ *** Date of Birth:** _____/_____/_____

*** Primary Diagnosis Code:** _____ Description: _____

*** Drug Allergies:** _____ ☐ No Known Drug Allergies ☐ Other Known Conditions: _____

*** Concomitant Medications:** _____ ☐ No Other Drug Therapies

Biomarker Test Result ☐ ROS1 ☐ NTRK ☐ KRAS G12 ☐ N/A ☐ Other: _____

	1. FREE TRIAL OFFER FOR ELIGIBLE PATIENTS†	2. BRIDGE PROGRAM FOR ELIGIBLE, COMMERCIAL PATIENTS‡	3. SPECIALTY PHARMACY Rx
COMPLETE FOR AUGTYRO	☐ AUGTYRO 40 mg capsules, 4 capsules once daily for 14 days, followed by 4 capsules twice daily. Dispense 180 capsules. 0 refills. ☐ Prescriber has provided patient with 30-day in-office sample.† Date: _____	☐ AUGTYRO 40 mg capsules. 4 capsules twice daily; 30-day supply with 1 refill. ☐ AUGTYRO 40 mg capsules Directions: _____ 30-day supply with 1 refill.	☐ **Starter Dose**: AUGTYRO 160 mg; once daily for 14 days, followed by 160 mg twice daily. 30-day supply with 0 refills. ☐ **Maintenance Dose**: AUGTYRO 160 mg twice daily. 30-day supply followed by 11 refills or_____refills. ☐ Other: _____
COMPLETE FOR KRAZATI	☐ KRAZATI 200 mg tablets, 3 tablets twice daily. Dispense 180 tablets, 30-day supply with 0 refills.	☐ KRAZATI 200 mg tablets, 3 tablets twice daily. Dispense 180 tablets, 30-day supply with 1 refill.	☐ KRAZATI 200 mg tablets, 3 tablets twice daily. Dispense 180 tablets, 30-day supply with 11 refills or _____ refills. ☐ KRAZATI 200 mg tablets. Directions: _____ Dispense ___ tablets, 30-day supply with 11 refills or ___ refills.

4. AUGTYRO OR KRAZATI PREFERRED SPECIALTY PHARMACY ☐ Onco360 ☐ Biologics ☐ Self-Dispensing Pharmacy_____

†For AUGTYRO, Free Trial Offer is not available if patient has received samples. ‡For additional eligibility requirements and terms and conditions, please click here.

PHYSICIAN CERTIFICATION

*** Prescriber Name:** _____

*** Address:** _____

*** Phone #:** _____ *** Fax:** _____ *** NPI #:** _____

I certify that I have read and will comply with the Program terms and conditions on page 5. I authorize the BMS Access Support Program to transmit the prescription(s) above by any means under applicable law to the appropriate dispensing pharmacy. If required by applicable law, please attach copies of all prescriptions on official state prescription forms. If you are in the state of AZ, FL, IA, or NY, please also send an electronic prescription (eRx) or fax prescription directly to the pharmacy for each prescription selected.

PRESCRIBER SIGNATURE† _____ Date: _____/_____/_____

†Signature stamps not acceptable. The prescriber is to comply with their state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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PRESCRIPTION INFORMATION FOR ZENBEXUS™ (iberdomide) *only*:

- A new prescription is required for patients referred to BMS Patient Assistance Foundation.
- ZENBEXUS prescriptions are only accepted via fax or through the **MyBMSCases.com** provider portal.

*** Patient Name:** _____ *** Date of Birth:** _____/_____/_____

*** Primary Diagnosis Code:** _____ Description: _____

*** Drug Allergies:** _____ ☐ No Known Drug Allergies ☐ Other Known Conditions: _____

*** Concomitant Medications:** _____ ☐ No Other Drug Therapies

COMPLETE FOR ZENBEXUS

1. FREE TRIAL OFFER FOR ELIGIBLE PATIENTS	2. BRIDGE PROGRAM FOR ELIGIBLE, COMMERCIALLY-INSURED PATIENTS†	3. SPECIALTY PHARMACY Rx
☐ ZENBEXUS 1 mg capsule per day taken orally on Days 1 through 21 of repeated 28-day cycle with 0 refills.	☐ ZENBEXUS 1 mg capsule per day taken orally on Days 1 through 21 of repeated 28-day cycle with ___ refills.	☐ ZENBEXUS 1 mg capsule per day taken orally on Days 1 through 21 of repeated 28-day cycle with ___ refills. ☐ ZENBEXUS ___ mg capsules. Directions: _____ Dispense ___ capsules, 21-day supply with 11 refills or ___ refills.

4. ZENBEXUS SPECIALTY OR IN-OFFICE DISPENSING PHARMACY WITHIN REMS NETWORK‡ _____

5. RISK CATEGORY FOR RX ☐ Female who can become pregnant (refills not available) ☐ Male (refills not available) ☐ Female who cannot become pregnant

†For additional eligibility requirements and terms and conditions, please click here.

‡For ZENBEXUS, providers and patients must follow Risk Evaluation and Mitigation Strategy (REMS) requirements. For information on REMS, please click here.

PHYSICIAN CERTIFICATION

*** Prescriber Name:** _____

*** Address:** _____

*** Phone #:** _____ *** Fax:** _____ *** NPI #:** _____

I certify that I have read and will comply with the Program terms and conditions on page 5. I authorize the BMS Access Support Program to transmit the prescription(s) above by any means under applicable law to the appropriate dispensing pharmacy. If required by applicable law, please attach copies of all prescriptions on official state prescription forms. If you are in the state of AZ, FL, IA, or NY, please also send an electronic prescription (eRx) or fax prescription directly to the pharmacy for each prescription selected.

PRESCRIBER SIGNATURE§ _____ Date: _____/_____/_____

§Signature stamps not acceptable. The prescriber is to comply with their state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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