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) | NULOJIX® (belatacept) | ORENCIA® (abatacept) | SOTYKTU® (deucravacitinib)

If you are enrolled in 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 are living in the U.S. or a U.S. territory during your eligibility period, **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 you have Medicare and have spent at least 3% of your yearly household income on your out-of-pocket (OOP) prescription expenses in the same calendar year you are applying to BMSPAF. For example, if you are applying for assistance for 2027, please attach 2027 OOP prescription expenses to this application.
- ☐ You do not qualify for the Medicare Part D Low-Income Subsidy (LIS) program (also called, "Extra Help"). Proof of denial will be required.
- ☐ Medicaid-eligible patients who are not enrolled in Medicaid will be required to submit proof of Medicaid denial.

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

HOW TO APPLY

Complete this application 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 BMSPAF is free.

There is no charge to submit your application.

PATIENT & PRESCRIBER INFORMATION CHECKLIST:

PATIENTS: COMPLETE SECTION I	PRESCRIBERS: COMPLETE SECTION II, III, IV
☐ Patient Information	☐ Treatment & Prescription Information
☐ Copies of Front & Back of Insurance Cards*	☐ Prescriber & Treatment Site Information
☐ Household Size & Income	☐ Shipping Address (if different)
☐ Out-of-Pocket Prescription Expenses*	☐ Sign & Date Prescriber Certification
☐ Sign & Date Patient Agreement & Consent	☐ Attach Prescription
☐ Initial Fair Credit Reporting Act Consent	

*If applicable.

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

ELIQUIS®, NULOJIX®, ORENCIA®, and SOTYKTU® are trademarks of Bristol-Myers Squibb Company.

BMSPAF Case #: _____ PO Box 220769, Charlotte, NC 28222-0769 | Phone: 800-736-0003 | Fax: 800-736-1611

Section I: PATIENT INFORMATION – To be completed by the patient. All boxes are required except where noted.

Patient Name:		
Date of Birth:	Gender: ☐ Female ☐ Male	
Patient Address *(no PO Boxes)*:		
City:	State:	ZIP:
Home Phone:	Cell Phone *(optional)*:	Email *(optional)*:

Complete the following section if you provide an alternate contact (*optional*): Please note that an alternate contact may not be an individual associated with or a representative of your insurance company or their business partners.

Alternate Contact Name: _____	Relationship: ☐ Family Member ☐ Friend ☐ Other *If Other, please specify relationship*: _____	Alternate Contact Phone: _____

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

☐ Medicare: ☐ Part A ☐ Part B ☐ Part C/Medicare Advantage ☐ Part D ☐ Part D LIS/Extra Help

☐ Medicaid ☐ VA or Military ☐ Private Insurance ☐ None ☐ Other:

PLEASE NOTE: If you are age 65 and over, have income less than 150% of the federal poverty level and have been prescribed ELIQUIS, ORENCIA Subcutaneous or SOTYKTU, you will be asked to provide proof of denial for the Medicare Part D LIS/Extra Help program. For more information, please visit BMSPAF.org or call 800-736-0003.

INSURANCE NAME	PHONE #	ID/POLICY #	
Primary:			
Secondary:			
Prescription Coverage:		ID/Policy #:	
If you have prescription coverage, attach a copy of both sides of your prescription insurance card.		RxBIN:	RxPCN:

PATIENT HOUSEHOLD INFORMATION – Please complete this section in its entirety.

Household Size *(include yourself, your spouse, and any dependents currently living with you)*:

Total Yearly Household Income: $	**OR**	Total Monthly Household Income: $

Total household income includes salary and wages, social security payments, income from retirement plans and pensions, alimony payments you receive, and interest and dividend income. These earnings added together for the entire household will give you your total household income. Your household income will also be assessed by initialing the Fair Credit Reporting Act Consent on page 3. If your income cannot be verified through the Fair Credit Report, proof of income may be requested.

Important Information

A U.S. home address is required for eligibility and shipping. BMSPAF reserves the right to request proof that you live in the U.S. or a U.S. territory while receiving medication from BMSPAF.

Medicare beneficiaries: You may be eligible for assistance if you have spent at least 3% of your annual household income on your out-of-pocket (OOP) prescription expenses in the same calendar year you are applying to BMSPAF.

For example, if you are applying for assistance for 2027, please attach 2027 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.

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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). • I will be living in the US or a US territory during my eligibility period. • If my insurance coverage, address, 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). • If I have a Medicare Part D or Medicare Advantage plan, the Medicare Prescription Payment Plan is an option that allows prescription drug costs to be paid in capped monthly payments rather than all at once, but I cannot afford the cost share for my prescribed BMS product(s). • 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. Fair Credit Reporting Act Consent is required.
We cannot process your application without this consent. Initialing here will not impact your credit score.

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Section II: PRESCRIPTION – To be completed and signed by a licensed prescriber. All boxes are required. *Note: NY prescriptions must be on official NY State Prescription Form.*

Patient Name: DOB:

☐ **ELIQUIS (apixaban)**
☐ **ORENCIA (abatacept) SC**
☐ **SOTYKTU (deucravacitinib)**

Dosage: _____
Sig: _____
Days' Supply: ☐ 90 ☐ 60 ☐ 30 ☐ Other: _____
Number of Refills: _____

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.

☐ **ORENCIA (abatacept) IV***
☐ **NULOJIX (belatacept)**

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

BSA/Weight: _____ ICD-10 Code: _____
Dosage: _____
Dosing Schedule: _____
Number of Doses Authorized†: _____

†Complete for up to a 4-week supply.

Section III: Prescriber Information

Prescriber Name: _____ | State License #: _____ | Title: ☐ MD/DO ☐ Other: (*Please specify*): _____ | NPI: _____

Office Name: | Office Phone: | Office Fax:

Office Address (*no PO Boxes*): | City: | State: | ZIP:

(*If Applicable*) Collaborating Physician: | Prescriber State License #: | Collaborating Physician NPI:

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

Contact Name/Title: _____ Contact Phone: _____ Contact 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** (*Treatment Site information below is required*):

Treatment Site Name: _____ | Treatment Site Address (City/State/ZIP): _____ | Treatment Site State License #: _____

Administering Physician Name (*optional*): | Administering Physician State License # (*optional*):

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, address, 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. (8) This patient is being treated with this medicine on an outpatient basis. 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.

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