Bristol Myers Squibb®
Access Support®

Kidney Transplant Access and Reimbursement Support

PHONE: 1-800-861-0048
FAX: 1-833-958-2087

Patient Name: Date of Birth:

Fields marked with ! are required to process form, including patient signature on page 3.

1. SERVICES REQUESTED: *To be completed by the Healthcare Provider*

- ☐ Benefits Review, Prior Authorization, Appeals Assistance
- ☐ BMS Access Support Kidney Transplant Co-Pay Assistance Program
- ☐ Identification of Potential Infusion Providers
  - *BMS cannot guarantee acceptance by any program*

For Co-Pay Assistance Program Terms and conditions, visit www.BMSAccessSupport.com/co-pay-financial-assistance

2. PATIENT INFORMATION:

Patients will need to sign the Patient Authorization & Agreement on page 3 in order to submit this form. If any information or patient signature is missing, it may cause delays.

! First Name: _____ MI: _____ ! Last Name: _____ ! Date of Birth: ___/___/_____ ! Gender: ☐ Male ☐ Female

! Address: _____ ! City: _____ ! State: _____ ! ZIP: _____

! Phone: _____ Email: _____

Patient-Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

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

Please note that an Alternate Contact may not be an individual associated with or a representative of your insurance company or their business partners.

PATIENT INSURANCE INFORMATION

Please complete all fields that apply. Remember to include a copy of the front and back of your insurance card for each type of insurance.

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

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

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

PRIMARY INSURANCE: ! Plan Name: _____ State: _____ ! Policy #: _____

! Group #: _____ ! Insurance Phone #: _____ Policy Holder Name (if not patient): _____

SECONDARY INSURANCE: Plan Name: _____ State: _____ Policy #: _____

Group #: _____ Insurance Phone #: _____ Policy Holder Name (if not patient): _____

PRESCRIPTION DRUG INSURANCE: ☐ Patient does not have prescription coverage

Plan Name: _____ Policy #: _____

Group #: _____ Rx BIN #: _____ Rx PCN #: _____

Insurance Phone #: _____ Policy Holder Name (if not patient): _____

Once you have completed this page, please proceed to the Patient Authorization and Agreement on pages 2-3.

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3. 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. To participate in the BMS Access Support program we will need to receive, use, and disclose your personal information. Please read this authorization for BMS 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 1-833-958-2087.

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 and their authorized agents and assignees (their "Administrators"). BMS 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
- 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
- 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.

(continued)

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PATIENT AUTHORIZATION AND AGREEMENT (cont.)

5. Notices:

I understand that once my health information has been disclosed, privacy laws may no longer restrict its use or disclosure. BMS 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 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® program. 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.

6. Patient certifications:

I certify that the personal information that I provide to BMS is true and complete. I agree that, at any time during my participation in either or both programs, BMS 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 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. I understand that the BMS Access Support program 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 https://www.MyBMSCases.com/BMS/ProviderLightningPortal/s/esign or by scanning the QR code here with a phone or tablet. You may also fax the documents to 1-833-958-2087 or call 1-800-861-0048 for further assistance.

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: _____

! SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE _____ 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, including 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: _____ Date of Birth: _____

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

HCP-ADMINISTERED THERAPY

☐ **NULOJIX (belatacept)**

! Primary Diagnosis Code: _____ Description: _____

TRANSPLANT CENTER INFORMATION

Transplant Center Name: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Contact Name: _____ Contact Role: _____

Contact Phone: _____ Contact Fax: _____

Transplant Physician Name: _____ Tax ID of Transplant Center: _____

REFERRING PHYSICIAN INFORMATION (HCP WHO REFERRED PATIENT TO THE TRANSPLANT CENTER)

Referring Physician Name: _____ Specialty: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Office Phone: _____ Fax: _____

5. PRESCRIBER INFORMATION: *To be completed by the Healthcare Provider for post-transplant patient care*

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

! Physician First Name: _____ ! Last Name: _____ ! State License #: _____

Treating Physician Specialty: _____

! Physician NPI #: _____ ! Prescriber Tax ID: _____ State Medicaid #: _____

! Facility Name: _____ ! Phone: _____ ! Fax: _____

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

! Address: _____ Suite: _____

! City: _____ ! State: _____ ! ZIP: _____

Is HCP above administering NULOJIX (belatacept) to this patient? ☐ Yes ☐ No › *If no, please complete the information below*

Infusion Site Name: _____ NPI#: _____

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

Office Contact Name: _____ Title: _____

Email: _____ Phone: _____

If identification of potential infusion sites is requested, indicate the date an alternate infusion site is needed: _____

Patient Name: **Date of Birth:**

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6. 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, 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 that the kidney transplant medication prescribed is of medical necessity;
4. 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 BMS for this patient, nor will I count the free medication towards this patient's true out-of-pocket costs (TrOOP); and
5. Any medication provided by BMS 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

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)