Bristol Myers Squibb®
Access Support®

# Oncology Access and Reimbursement Support

**PHONE:** 1-800-861-0048
**FAX:** 1-888-776-2370

*You can also complete this form online at: www.bmsaccesssupportesign.com*

**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 Co-Pay Assistance Program**
- ☐ **Benefits Review of Specialty Pharmacy**
  Preferred SP:___________________________
- ☐ **Free Trial Offer, Bridge Program, Specialty Pharmacy Rx**
  Available only for AUGTYRO™ (repotrectinib). Prescription required. See page 6.
- ☐ **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.*

For complete program terms and conditions visit www.BMSAccessSupport.com

## 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.*

## 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 $ _________

## 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 (e.g. 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.*

PHONE: 1-800-861-0048
FAX: 1-888-776-2370

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

## 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. 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 PO 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.

*(continued)*

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

## 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, 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.

**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 **https://www.bmsaccesssupport.bmscustomerconnect.com/sign** or by scanning the QR code below 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 it 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: ______________________________

**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.

# Oncology Access and Reimbursement Support

PHONE: 1-800-861-0048
FAX: 1-888-776-2370

*You can also complete this form online at: www.bmsaccesssupportesign.com*

**Patient Name:** **Date of Birth:**

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

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

| IV THERAPY | ORAL THERAPY |
|---|---|
| ☐ **EMPLICITI®** (elotuzumab) ☐ **OPDUALAG™** (nivolumab and relatlimab – rmbw) | ☐ **SPRYCEL®** (dasatinib) |
| ☐ **OPDIVO®** (nivolumab) ☐ **OPDIVO®** (nivolumab) + **YERVOY®** (ipilimumab) | ☐ **AUGTYRO™** (repotrectinib) For Free Trial Offer and Bridge Program, see pg. 6 |
| ☐ **YERVOY®** (ipilimumab) | |

! 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: ____________

! Has the patient started therapy? ☐ Yes ☐ No Date of Treatment:___/___/_____ Dosing: ____________

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

Line of Therapy: ☐ Neo-Adjuvant ☐ Adjuvant ☐ First ☐ Second ☐ Other: ____________

Primary Tumor Type: ____________ Histology: ____________ Stage: ____________

Biomarker Test Result: ☐ PD-L1 positive ☐ EGFR / ALK positive ☐ ROS1-positive ☐ dMMR/MSI-H ☐ N/A Other: ____________

! Medications dispensed through: ☐ Buy and Bill ☐ Specialty Pharmacy

! IV treatment to be administered in: ☐ Physician's Office ☐ Outpatient ☐ Other: ____________

## 5. PRESCRIBER INFORMATION: *To be completed by the Healthcare Provider*

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

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

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

! Facility Name: ____________ ! Phone: ____________ ! Fax: ____________

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

! Address: ____________ Suite: ____________

! City: ____________ ! State: ____________ ! Zip: ____________

Office Contact Name: ____________ Title: ____________

Email: ____________ Phone: ____________

**PHONE:** 1-800-861-0048
**FAX:** 1-888-776-2370

*You can also complete this form online at: www.bmsaccesssupportesign.com*

**Patient Name:** **Date of Birth:**

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

## 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, 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.

_______________________________________ Date:___/___/_____

*(Physician or Licensed Prescriber Signature (required—no stamps)*

Bristol Myers Squibb®
Access Support® >

# Oncology Access and Reimbursement Support

PHONE: 1-800-861-0048
FAX: 1-888-776-2370
*You can also complete this form online at: www.bmsaccesssupportesign.com*

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

## 7. PRESCRIPTION INFORMATION FOR AUGTYRO™ (repotrectinib): *To be completed by the Healthcare Provider*

> ***This section should only be completed if AUGTYRO™ is the medication being prescribed.***
> A new prescription is required for patients referred to BMS Patient Assistance Foundation.
> AUGTYRO™ 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

! Concomitant Medications: ______________ ☐ No Other Drug Therapies    Other Known Conditions: ______________

### 1. SELECT FREE TRIAL OFFER*

Optional Free Trial Offer for Eligible Patients

☐ AUGTYRO™ 40mg capsules, 4 capsules once daily for 14 days, followed by 4 capsules twice daily. Dispense 180 capsules. 0 refills.

OR

☐ Prescriber has provided patient with 30-day in-office sample*

Date: ______________

### 2. SELECT BRIDGE PROGRAM†

Optional Bridge Program for Eligible, Commercially Insured Patients

☐ AUGTYRO™ 40mg capsules. 4 capsules twice daily; 30-day supply with 1 refill

☐ AUGTYRO™ 40mg capsules. Directions: ______________ 30-day supply with 1 refill

### 3. SELECT SPECIALTY PHARMACY Rx

☐ **Starter Dose**: AUGTYRO™ 40mg capsules, 4 capsules once daily for 14 days, followed by 4 capsules twice daily. Dispense 184 capsules. 0 refills

☐ **Maintenance Dose**: AUGTYRO™ 40mg capsules. 4 capsules twice daily

☐ 30-day supply followed by 11 refills or ______refills

OR

☐ 90-day supply followed by 3 refills or ______refills

☐ Other: ______________

### 4. PREFERRED SPECIALTY PHARMACY

Preferred Specialty Pharmacy Name: ______________ ☐ Self-Dispensing Pharmacy

†Please see additional eligibility requirements and terms and conditions at www.BMSAccessSupport.com. *Free Trial Offer is not available if patient has received samples.

### PRESCRIBER AUTHORIZATION

! Prescriber Name: ______________

! Address: ______________

! Phone #: __________ ! Fax: __________ ! NPI #: __________ If mid-level practitioner, supervising MD__________

I certify that (1) I have prescribed AUGTYRO™ based on my professional judgment of medical necessity and that I will supervise the patient's medical treatment; (2) I have the authority to disclose this patient's information to BMS and its respective agents and service providers, including the dispensing pharmacy, and I have obtained this patient's authorization for the disclosure, if required by HIPAA or other applicable privacy laws; (3) the information provided is accurate to the best of my knowledge; (4) I will not seek reimbursement for any free product provided to the patient; and (5) I have read and will comply with the Program terms and conditions. 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 ______________ *Dispense as written** ______________ *Substitutions allowed* 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.

©2023 Bristol-Myers Squibb Company. Access Support is a registered trademark of Bristol-Myers Squibb Company. ONC-US-2300789 10/23