Provider User Guide

Online Enrollment With e-Signature

If you require additional assistance, please call BMS Access Support® at **1-800-861-0048**.

Introducing Online Enrollment with HCP and Patient e-Signature

Online enrollment for BMS Access Support® is now available.

This guide outlines step-by-step how to complete the online enrollment form for BMS Access Support®. Through this process, you can request services such as a Benefits Review, the BMS Access Support Co-Pay Assistance Program, or Alternative Coverage/Support Research.

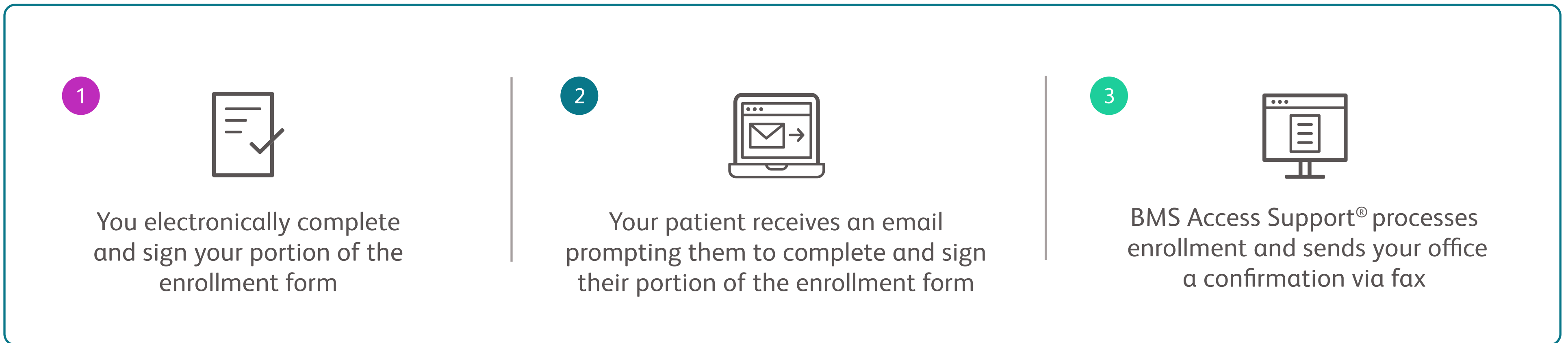


Table of Contents

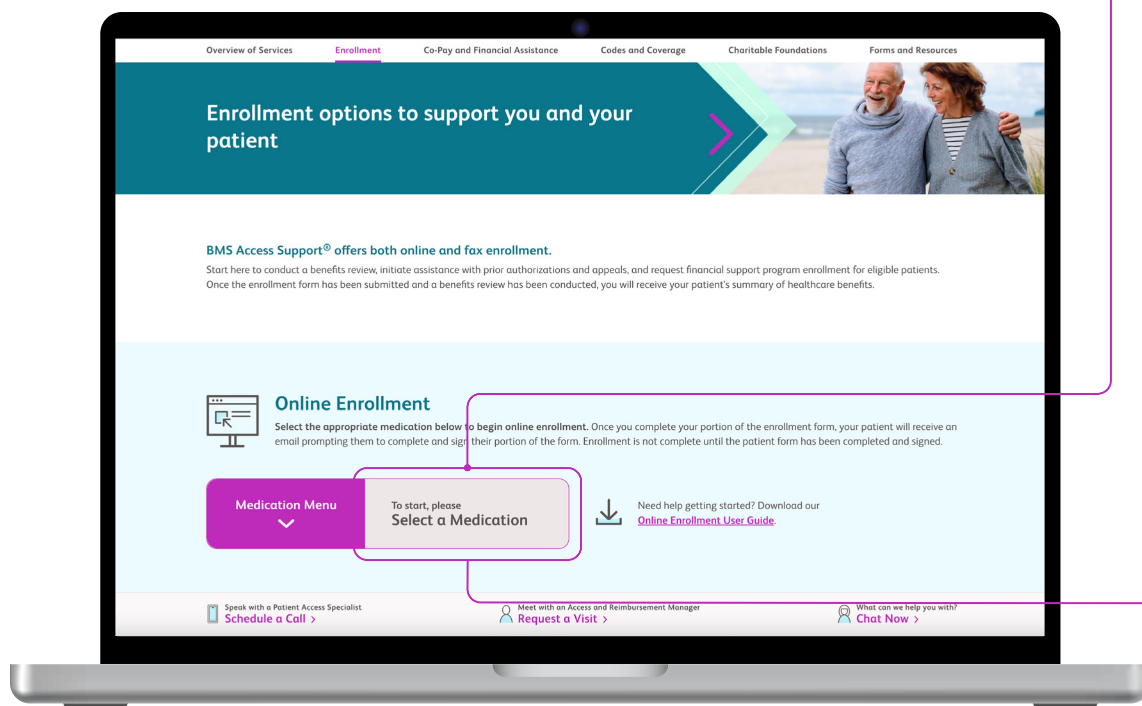
How to Access Online Enrollment 3
Healthcare Provider Enrollment Process 4
Patient Enrollment Process 8
How To Get Support 10

How to Access Online Enrollment

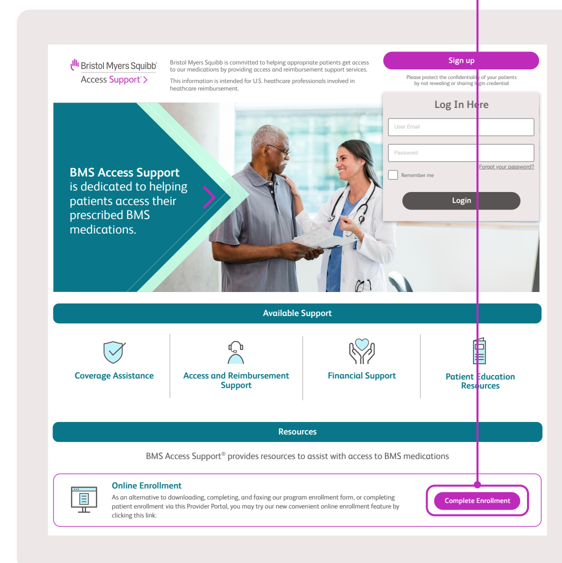
There are two ways to access the online enrollment form for services through BMS Access Support®:

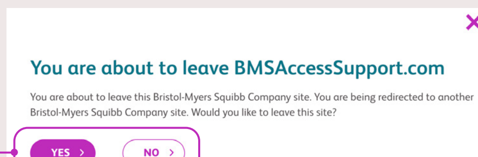
1. Enrollment page within the HCP BMS Access Support® website at **www.BMSAccessSupport.com/hcp**
2. Via the MyBMSCases portal landing page

1 **Online Enrollment** is prominently displayed. Select the medication that your patient has been prescribed to get started.



2 **Online Enrollment** is prominently displayed. Click **Complete Enrollment** to begin.





You will be notified that you are about to leave BMSAccessSupport.

Prefer to fax the completed enrollment form? PDF versions are available to download at **www.BMSAccessSupport.com/hcp**.

Healthcare Provider Enrollment Process

1. Before you are brought to the online enrollment form, you will need to fill out an initial information intake to confirm:
   a. Your first/last name and email **b.** Patient's first/last name and email
2. Then, confirm and acknowledge that everything listed is accurate before clicking **Begin Signing**.

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This Enrollment form is to be completed by both healthcare provider and patient. The provider must complete his or her section of the enrollment form and initiate a request for the patient's authorization. The patient will receive an email with link to review the enrollment form and provide the required information and signature. Once the form has been completed by the patient, a copy will be sent to the patient and the appropriate Bristol Myers Squibb Patient Support Program to begin processing the patient enrollment.

* Healthcare Provider Name
Provider | Test

* Healthcare Provider Email
provider.test@test.com

* Patient Name
Patient | Test

* Patient Email
patient.test@test.com

☑ I certify that I have obtained from this patient a valid HIPAA Authorization that allows for this disclosure to the program, and I agree that the program may contact this patient to obtain their signature on the enrollment form.

Begin Signing

1a Fill in your information. **You will not be able to proceed without a valid email.**

1b The patient's name and email are required to proceed with the enrollment.

2 Confirm and acknowledge that everything listed is accurate.

NOTE: A valid healthcare provider and patient email are required. The same email address cannot be entered into the healthcare provider and patient designated email fields—these must be unique values.

Healthcare Provider Enrollment Process (continued)

After submitting the initial contact information, you will see an editable digital version of the BMS Access Support® Enrollment Form that is specific to the product you previously selected.

1 FORM HEADER

The patient's name will automatically populate based on the initial intake form. You will need to add the patient's date of birth.

2a SERVICES

Benefits Review, Prior Authorization, Appeals Assistance must be checked. The other services are optional.

2b SERVICES

If **Benefits Review of Specialty Pharmacy** is selected, be sure to provide the name of the preferred specialty pharmacy.

3 TREATMENT

Only one treatment option can be selected.

4 TREATMENT

Populate the patient's previous treatment information in the Treatment Information section.

Healthcare Provider Enrollment Process (continued)

5 Your name will automatically populate based on the information entered on the initial intake form. You will need to fill in all additional information.

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.

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: ____

6 Once you have reviewed the **PHYSICIAN CERTIFICATION**, sign and date the form using Adobe Sign.

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.

! SIGNATURE ____ Date: __/__/____

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

Type | Draw | Image | Mobile

Sign

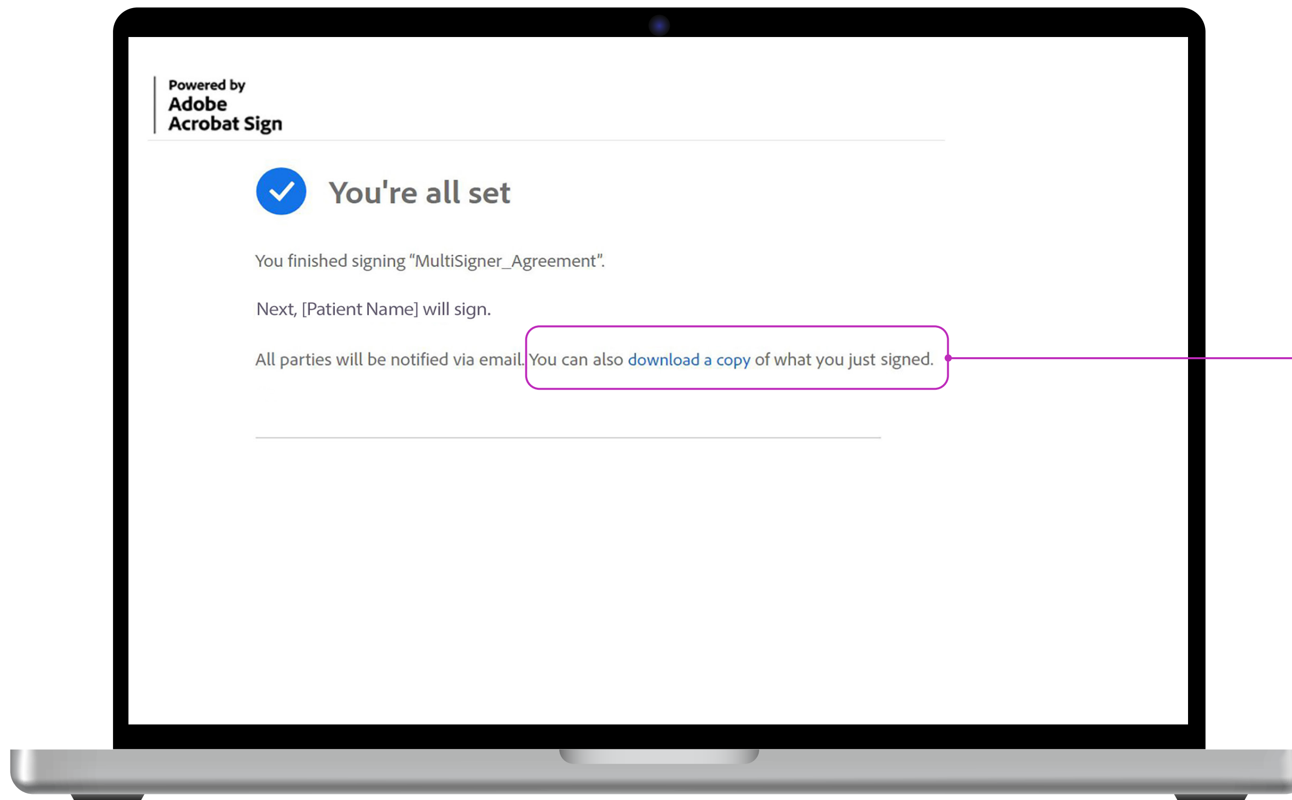
Type your signature here

Close | Apply

Healthcare Provider Enrollment Process (continued)

Once you submit, the form will automatically be routed to the patient for their review and signature.

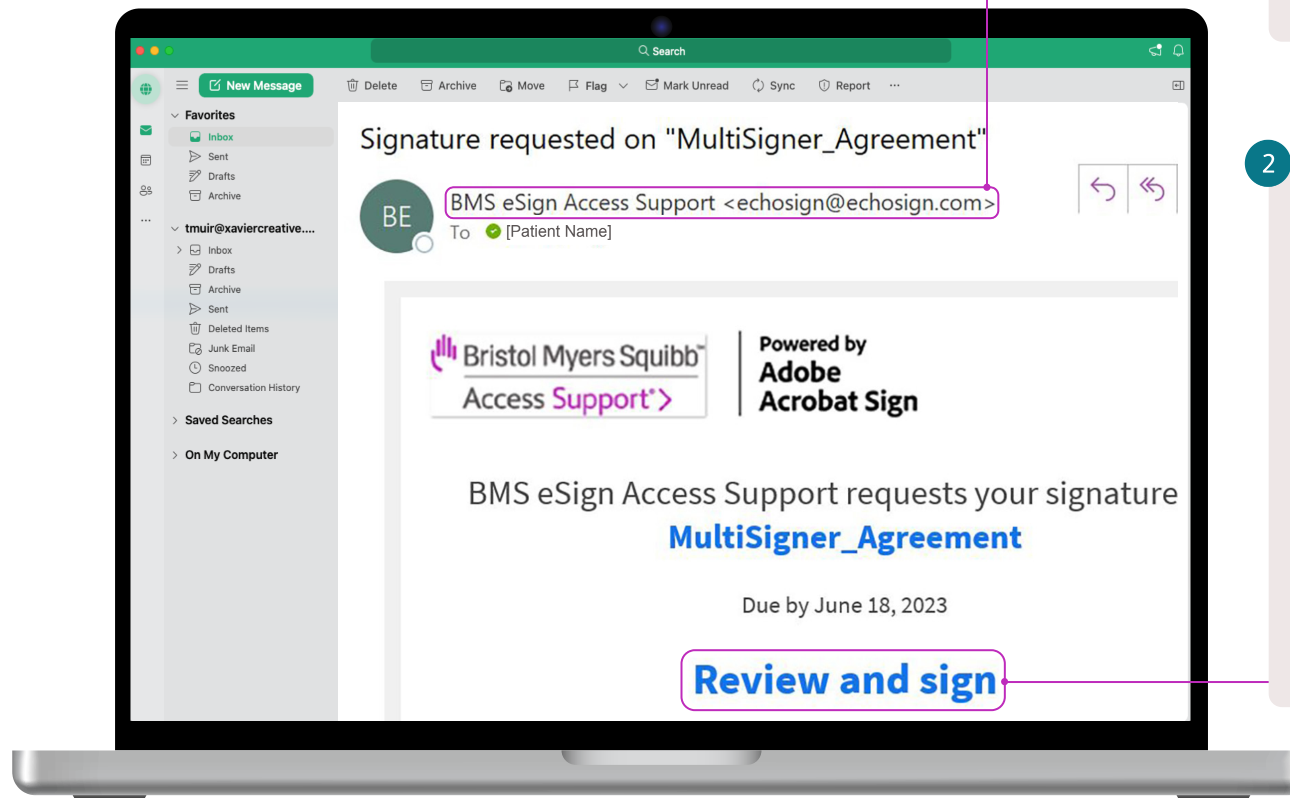
You can download a copy of your portion of the enrollment form for your records.



NOTE: If the patient does not review and sign within 10 days, your portion of the enrollment form will be deleted, and the enrollment **WILL NOT BE PROCESSED.**

Patient Enrollment Process

After your portion of the enrollment form is completed, the patient will receive a signature request email at the email address provided during the initial intake. The form can be completed on a desktop, tablet, or mobile device.



1. Encourage your patients to check their inbox or spam folder for an email from BMS eSign Access Support.

2. The patient clicks **Review and sign** to review and acknowledge their part of the enrollment form. **Enrollment cannot proceed without patient consent on file. BMS Access Support® will not receive any portion of the enrollment form until patient consent is provided.**

NOTE: A reminder email is sent every 3 days for 10 days. If the patient does not review and sign within 10 days, the provider portion of the enrollment form will be deleted, and the enrollment **WILL NOT BE PROCESSED**.

Patient Enrollment Process (continued)

Once the patient submits the enrollment form, the form will automatically be routed to BMS Access Support® for enrollment. The patient can also download a copy of the form for their records.

1. The patient will review the form you completed and enter any additional information that may be required.

2. Once the patient has reviewed the enrollment form, they will sign and date the form using Adobe Sign.

Once your patient completes and submits their portion of the enrollment form, the online enrollment process is complete! You will receive a confirmation of the enrollment from BMS Access Support® via fax.

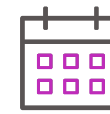
How To Get Support

Looking for support? We're here for you.

Patient access support, reimbursement resources, and financial support options may be available through **BMS Access Support®**

Call a Patient Access Specialist at **1-800-861-0048**, 8 AM to 8 PM ET, Monday - Friday

Visit **www.BMSAccessSupport.com**



Schedule a meeting with a BMS Access and Reimbursement Manager on the BMS Access Support website

The accurate completion of reimbursement- or coverage-related documentation is the responsibility of the healthcare provider and patient. Bristol Myers Squibb and its agents make no guarantee regarding reimbursement for any service or item.

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