Destination Access™

Bristol-Myers Squibb

ERBITUX / IXEMPRA
PATIENT ASSISTANCE PROGRAM
6900 College Boulevard, Suite 1000
Overland Park, KS 66211
Phone: 800-861-0048 ◆ Fax: 888-776-2370

TO:		**FROM:**	
FAX:		**PAGES:**	
RE:		**DATE:**	

Thank you for your interest in the Bristol-Myers Squibb Destination Access Program. This program is designed to help patients with any reimbursement needs regarding **ERBITUX® (cetuximab) or IXEMPRA® (ixabepilone)**, such as benefit investigations, prior authorization or appeals assistance. The Destination Access Program also provides free product to qualified uninsured patients, including individuals with insurance who have received a denial from their insurer based on product coverage, and who meet the program's eligibility criteria.

SIMPLE 3-STEP REGISTRATION:

✓ STEP 1 - PATIENT REQUIREMENTS:

- Complete all sections on Page 1 of the Patient Enrollment Form.
- Please indicate "0" or "NO," if appropriate, rather than leaving any field blank.
- **Sign and date the enrollment form**. If the patient is unable to sign the enrollment form, their power of attorney may sign in their place. If the signature is other than the patient's, please provide an explanation.
- Do **NOT** provide a P.O. Box for the street address. Patient must live in the U.S., Puerto Rico, or the U.S. Virgin Islands.

ONLY SUPPLY PROOF OF INCOME INFORMATION BELOW IF APPLYING FOR FREE PRODUCT:

- Please attach a photocopy of proof of yearly household adjusted gross income. Examples include: Federal tax return (1040) ***(preferred)***, Social Security income (SSA 1099), pensions, interest, retirement, child support, etc.
- Include **TOTAL YEARLY HOUSEHOLD ADJUSTED GROSS INCOME**. Can be obtained from the Internal Revenue Service Individual Income Tax Return Forms 1040 EZ (line 4), 1040 A (line 21) or 1040 (line 37).

✓ STEP 2 - HEALTHCARE PROVIDER REQUIREMENTS:

- Complete all sections on Page 2 of the Enrollment Form.
- Provide both DEA # and State License information.
- **Sign and date the Enrollment Form**. Stamped signatures or signatures by persons other than the prescribing healthcare provider are not acceptable.
- Do **NOT** provide a P.O. Box for the shipping address.
- **Provide copies of insurance cards (front & back), enlarged if possible.**
- Please complete the prescription information, including product name, dose/strength and frequency.

✓ STEP 3 - FAX OR MAIL APPLICATION FORM:

FAX #: (888) 776-2370

MAIL: Destination Access
6900 College Boulevard, Suite 1000
Overland Park, KS 66211

Incomplete or incorrect information may delay the process, so please ensure all information is provided correctly and signatures are obtained.

We recommend that you return the completed form via fax in order to expedite the process. Once the enrollment form is received, Destination Access will notify the patient's healthcare provider of the results and any additional assistance options which may be available. Should you have any questions, please call (800) 861-0048. Our customer service administrators are available between the hours of 8:00 AM and 8:00 PM Eastern Standard Time, Monday through Friday (excluding holidays). Please note that Program rules are subject to change without notice.

Attachment

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Case #: Date:

✓PATIENT INFORMATION: THIS PAGE TO BE COMPLETED BY PATIENT *(Please print or type)*

PATIENT NAME (FIRST AND LAST): _____

GENDER: ☐ M ☐ F **DATE OF BIRTH:** _____ **DAYTIME PHONE #:** _____

STREET ADDRESS WHERE YOU LIVE: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

SOCIAL SECURITY # : _____

✓PATIENT FINANCIAL INFORMATION: ** PROOF OF INCOME REQUIRED ONLY IF APPLYING FOR FREE PRODUCT*

TOTAL YEARLY ADJUSTED GROSS INCOME FOR YOUR ENTIRE HOUSEHOLD

(Before Taxes):$_____

Includes salary, pension, Social Security, disability, alimony, child support, interest/dividends, rental property income, etc.

Proof of income includes: Copy of Federal tax return, W-2 or copy of recent paystub, copy of Social Security check or awards letter, etc.

Did you file a Federal tax return for the most current year? ☐ YES ☐ NO

If no, sign below if you agree to allow the IRS to confirm to Bristol-Myers Squibb (BMS) or its agents that you did not file a Federal tax return for the most current tax year.
IF NO:
Patient Signature: _____ Date: _____
PLEASE NOTE: The IRS does not manage the use of this information for determining enrollment in the Destination Access Patient Assistance Program. In addition, the IRS may contact you regarding your request.
IRS: Please send verification to the address listed at the top of the application.

✓PATIENT INSURANCE INFORMATION: **PLEASE INCLUDE A COPY OF INSURANCE CARDS, FRONT AND BACK*

Does the patient have Medicare Coverage: ☐ **YES** ☐ **NO**
If Yes, check all that apply: ☐ **Part A** ☐ **Part B** ☐ **Part D** ☐ **Medicare Advantage**

MEDICARE POLICY #: _____ **EFFECTIVE DATE:** _____

If the patient has PART D or Medicare Advantage, list Prescription Drug Plan information below.

	INSURANCE NAME:	PHONE #:	ID/POLICY #:	POLICY HOLDER:
PRIMARY:				
SECONDARY:				
STATE, VETERAN OR OTHER PLAN:				

MEDICAID: ☐ Not Applied ☐ Denied ☐ Pending Coverage **VETERAN?** ☐ YES ☐ NO **Applied for VA?** ☐ YES ☐ NO

I promise that the information that I have provided on this application form is true and complete.

I authorize the release of the information contained on this application to BMS, its agents and the Destination Access Program (Program) and give these parties permission to share my personal information with my insurance company, doctor, pharmacist, or any person(s) whom I have elected to help me in applying for the Program to decide if I qualify to participate in the Program or other public or private assistance programs. I authorize my insurance company, doctor or pharmacist to disclose information relative to my medical condition, treatment or drug therapy to BMS and its agents.

I understand that BMS, its agents and the Program will only ask for the information that is needed to process my application, to renew it, and to provide me with help throughout my participation in the program. The Program will only share my information as stated above or as required by law. I understand that my authorization is in effect for as long as I participate in the Program and that Program rules are subject to change at any time.

Patient/Legal Guardian Signature: _____ Date: _____

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PATIENT NAME (FIRST AND LAST): _____

✓PROVIDER INFORMATION: THIS PAGE TO BE COMPLETED BY PROVIDER *(Please print or type)*

PHYSICIAN NAME: _____ **NPI:** _____

STATE LICENSE #: _____ **DEA#** _____ **TAX ID #:** _____

FACILITY NAME: _____ **PHONE #:** _____

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

MEDICAID PROVIDER # AND PIN: _____ **BCBS PROVIDER #:** _____

CONTACT NAME: _____ **CONTACT TITLE:** _____

CONTACT PHONE: _____ **EXT:** _____ **CONTACT FAX:** _____

✓DIAGNOSIS AND PRESCRIPTION INFORMATION

PATIENT DIAGNOSIS -- ICD-9 CODE: _____ **DESCRIPTION:** _____

WILL THIS BE? ☐ MONOTHERAPY ☐ IN COMBINATION WITH: _____

THERAPY PROVIDED IN: ☐ DOCTOR'S OFFICE ☐ HOSPITAL OUTPATIENT FACILITY

IS DOCTOR CONTRACTED WITH PATIENT'S INSURANCE? ☐ YES ☐ NO

FOR ERBITUX mCRC PATIENTS ONLY: ☐ KRAS Wild Type ☐ KRAS Mutant ☐ Not KRAS Tested

ERBITUX patients only: ☐ EGFR Positive ☐ EGFR Negative ☐ Not EGFR Tested

PRODUCT PRESCRIBED: ☐ **ERBITUX (cetuximab)** ☐ **IXEMPRA (ixabepilone)**

Outpatient Therapy GIVEN			Outpatient Therapy PLANNED		
DATE(S):	DOSE:	FREQUENCY:	DATE(S):	DOSE:	FREQUENCY:

✓SHIPPING INFORMATION: **INFORMATION REQUIRED IN THIS SECTION ONLY IF APPLYING FOR FREE PRODUCT*

If shipping address is the same as the mailing address provided, please confirm by checking the box. If not, please indicate shipping address below. ☐ **Shipping Address Is Same As Mailing Address**

Shipping Address: _____

City: _____ **State:** _____ **Zip:** _____

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I verify that the patient and physician information contained in this Enrollment Form is complete and accurate to the best of my knowledge and that I have prescribed the product based on my professional judgment of medical necessity.

I certify that, to the best of my knowledge, if the patient receives free product through the Destination Access Patient Assistance Program, the patient referenced above does not have any assistance with prescription drug costs for the product from private or public sources, will forego any appeal of any denial of insurance coverage for this medication if provided free-of-charge by the Destination Access Patient Assistance Program, and it would present a financial hardship for this patient to cover the cost of this medication. I agree to immediately notify the program representative if the patient's insurance or income status changes. I represent that the patient information I have provided is accurate and consistent with applicable privacy laws and regulations, and I understand that BMS and/or its agents are relying on this representation. I further certify that no reimbursement of the cost of product will be accepted by me from public or private sources, including patients, for any treatments where product will be provided free-of-charge by BMS.

Physician Signature: _____ **Date:** _____