BRISTOL-MYERS SQUIBB PATIENT ASSISTANCE FOUNDATION, INC.
ABILIFY PATIENT ASSISTANCE PROGRAM

P.O. Box 8309
Somerville, NJ 08876
Phone: (800) 736-0003
Fax: (866) 598-5561

Dear Applicant,

Thank you for your interest in the ABILIFY Patient Assistance Program. Enclosed you will find the application form you had requested.

It is important that you complete all requested information and sign where indicated. Incomplete or incorrect applications will delay the application process so please ensure all information provided is correct.

PATIENT REQUIREMENTS:

- ✓ Complete and sign Patient Information section
- ✓ Attach a photocopy of the ANNUAL household income. (Federal tax return (1040), social security income (SSA 1099), pensions, interest, retirement, child support, etc.)
- ✓ **If you have applied for Medicaid in the past and been denied, please attach copy of Medicaid denial. In the event that a letter of Medicaid denial is unavailable at the time the application is submitted, if approved, an initial 90-day supply will be issued. This will provide you with additional time to obtain a copy of this letter.**

HEALTHCARE PROVIDER REQUIREMENTS:

- ✓ Complete and sign Healthcare Provider Information section
- ✓ Complete the section for RX instructions; including drug name, strength and quantity per day
- ✓ List a shipping address of an authorized healthcare facility. Product will not be shipped to a patient's home or to a PO Box.
- ✓ Complete the ENTIRE application when requesting a change of dosage for an existing patient. Indicate "YES" on the, "change to dosing schedule" portion of the application and provide the new RX instructions
- ✓ Complete the entire application. The submission of incomplete applications will delay processing.
- ✓ Please do not attach a prescription to the application form.

SUBMIT COMPLETED APPLICATIONS BY SELECTING ONE OF THE FOLLOWING OPTIONS:

- ✓ MAIL: ABILIFY Patient Assistance Program
  P.O. Box 8309
  Somerville, NJ 08876
- ✓ FAX: 1-866-598-5561 (Please DO NOT fax multiple submissions of the application)

Once the application is received, eligibility will be evaluated for participation in the ABILIFY Patient Assistance Program. You and your patient will be notified by mail upon completion of eligibility review. Please note, program rules are subject to change without notice.

If you have questions or need further assistance, please call 1-800-736-0003, between 9:00 AM and 6:00 PM Eastern Time, Monday through Friday.

Sincerely,

Bristol-Myers Squibb
Patient Assistance Foundation, Inc.

Enclosure

BRISTOL-MYERS SQUIBB PATIENT ASSISTANCE FOUNDATION, INC.

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Bristol-Myers Squibb LifeLines OF CARE PATIENT ASSISTANCE FOUNDATION

PATIENT INFORMATION

First Name: MI: Last Name: Date of Birth: / /

Mailing Address: Apt #:

City: State: Zip Code:

Social Security Number: Gender Male/Female: Phone number: ( ) Contact Name:

Number of people in household: Is patient a U.S. Citizen or legal resident alien? ☐ YES ☐ NO

PATIENT FINANCIAL INFORMATION

Annual Gross Household Income	Patient/Spouse	Amount		Patient/Spouse	Amount
Salary Wages/Self-Employment (before deductions)			IRA or 401K Distributions		
Unemployment Compensation/Workers Compensation			Interest/Dividends/Royalties		
SS – Social Security Retirement/Survivor			General Relief/Public Assistance (i.e., TANF)		
SSDI – Social Security Disability Income			Alimony/Child Support		
SSI – Supplemental Security Income			Educational Grants/Scholarships		
Disability Payments (from Employer)			Other, please explain:		
Pension/Retirement/Military Pension/Veterans Benefits					

Total Annual income before taxes: Including all Income, Wages, Social Security, Pension, Disability, Interest Earned or Savings, etc. **Total** $

Did you file a Federal Tax Return for the most current tax year? **Yes** ☐ **No** ☐ If no, sign below if you agree to allow the IRS to confirm to the Bristol-Myers Squibb Patient Assistance Foundation that you did not file a Federal tax return for the most current tax year.

Patient Signature for Application: _____ **Date** _____

PLEASE NOTE: *The IRS does not manage the use of this information for determining enrollment in the Bristol-Myers Squibb Patient Assistance Foundation. In addition, the IRS may contact you regarding your request.* **IRS: Please send verification to the address listed at the top of the application.**

Private Insurance	Yes ☐ No ☐	Medicare A	Yes ☐ No ☐
Prescription Drug Coverage	Yes ☐ No ☐	Medicare B	Yes ☐ No ☐
Medicaid (Please attach copy of Medicaid card)	Yes ☐ No ☐	Medicare D	Yes ☐ No ☐
Have you applied for Medicaid in the past and been denied? (If so, please attach copy of Medicaid denial.)	Yes ☐ No ☐	VA or Military Benefits	Yes ☐ No ☐

I attest that the above information is complete and accurate. I attest that I have no prescription insurance coverage for the indicated medication, including Medicaid, Medicare or any other public or private program and I have insufficient financial resources to pay for the prescribed therapy. By my signature, I authorize the release of information about me and my medical condition to the Bristol-Myers Squibb Patient Assistance Foundation (BMSPAF), and/or their agents. I authorize the BMSPAF, and/or their agents to use and disclose such information for the assessment of my eligibility for, enrollment into the BMSPAF and administration of the BMSPAF, which may include contacting my insurer, public funding programs, social workers, advocacy organizations, healthcare providers, or other persons or entities the BMSPAF may deem appropriate, to release all medical records or requested information bearing on my eligibility to and benefits under the program. Additionally, I agree that at any time during my enrollment, the BMSPAF may request additional documentation to authenticate the statements made on my application. The BMSPAF and/or their agents agree not to disclose any information to any third party except as authorized by me or as required by law. I understand and acknowledge that this assistance is temporary and that this program may be changed or discontinued at any time without notice. I understand that the BMSPAF, and/or their agents are relying on this information.

Patient Signature: _____ Date: _____

Advocate Signature: _____ Date: _____

HEALTHCARE PROVIDER INFORMATION TO BE COMPLETED BY THE PRESCRIBING PRACTITIONER

First Name: Last Name: Professional Designation:

DEA# (If not available, please provide copy of State License): E-Mail Address:
State License #:

Shipping Address 1: (Drugs cannot be shipped to the patient or P.O. Box)

Shipping Address 2:

City State: Zip Code: Diagnosis Code:

Contact Name: Phone Number: ( ) Fax: ( )

REQUESTED MEDICATION (PLEASE CHOOSE):

☐ ABILIFY **Oral Solution 150 mL** ____ Qty / Day
☐ ABILIFY **2mg** ____ Qty / Day
☐ ABILIFY **5mg** ____ Qty / Day
☐ ABILIFY **10 mg** ____ Qty / Day
☐ ABILIFY **15mg** ____ Qty / Day
☐ ABILIFY **20 mg** ____ Qty / Day
☐ ABILIFY **30 mg** ____ Qty / Day

☐ ABILIFY 10mg **DISCMELT®** ____ Qty / Day
☐ ABILIFY 15mg **DISCMELT®** ___ Qty / Day

Is this a change in dose schedule for an existing BMSPAF member? ☐ YES ☐ NO

I represent that any information I have provided about this patient is complete, accurate and consistent with applicable privacy laws and regulations, and I understand that the BMSPAF, and/or their agents are relying on this information. To the best of my knowledge, this patient has no prescription insurance coverage for the indicated medication, including Medicaid, Medicare or other public or private programs. I acknowledge and agree not to submit an insurance claim or other claim for payment to any third-party payor (private or government) for the medication. I understand that BMSPAF reserves the right to modify or terminate this program at any time. My signature certifies that the medication received from BMSPAF will not be resold nor offered for sale, trade or barter and will not be returned for credit. I understand that BMSPAF reserves the right to recall or discontinue product at any time without notice.

Healthcare Provider Signature: _____ Date: _____