BRISTOL-MYERS SQUIBB ONCOLOGY
Destination Access™

REIMBURSEMENT SUPPORT 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 **YERVOY™ (ipilimumub)**, such as benefit investigations, prior authorization or appeals assistance. Bristol-Myers Squibb 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.

✓ 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:

✓ PLEASE INDICATE THE TYPE OF SERVICE NEEDED:

☐ **Benefit Investigation** ☐ **Prior Authorization** ☐ **Appeals** ☐ **Co-Pay Program**

✓ 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 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

PRODUCT PRESCRIBED: ☒ YERVOY (ipilimumab)

Outpatient Therapy GIVEN				Outpatient Therapy PLANNED			
DATE(S):	DOSE:		FREQUENCY:	DATE(S):	DOSE:		FREQUENCY:
	(mg/kg)	(mg)			(mg/kg)	(mg)	

✓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:** _____

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✓OFFERING COST SHARING ASSISTANCE YERVOY

Bristol-Myers Squibb Destination Access is committed to helping patients gain access to life saving drugs by providing assistance with the high out of pocket cost that patients face with their oncology treatments. Bristol-Myers Squibb is offering cost sharing assistance for those patients being treated with **YERVOY™ (ipilimumub).**

✓ HOW THE CO-PAY PROGRAM WORKS

❶ **Complete attached application and certification form and submit to Destination Access**

❷ **Destination Access will verify benefits and qualify your patient for the YERVOY™ Co-Pay Program, notifying the patient and the healthcare provider of approval and next steps**

❸ **Healthcare provider submits claims to Primary Insurance. Once 835/EOB (Explanation of Benefits) comes back, remaining cost share is submitted by your billing department to the Destination Access YERVOY™ Co-Pay Program.**

❹ **On a weekly basis, Destination Access will process the claim for remaining cost share after a patient responsibility of $50 out of pocket per infusion with the Co-Pay Program paying a maximum of $5,000 per patient for up to 4 infusions**

❺ **Healthcare provider will receive a check and 835/EOB for the qualified cost share amount**

✓PATIENT ELIGIBILITY CRITERIA .

➔ **Have commercial insurance that covers YERVOY but the insurance does not cover the full cost**

➔ **Have been prescribed YERVOY as per the FDA-approved package insert**

➔ **Eligible patients exclude patients who participate in a federal or state government-related healthcare program which pays in whole or in part for prescription drugs, such as Medicare, Medicaid, TRICARE or VA programs**

➔ **Must be a resident of the United States or Puerto Rico and be 18 years or older**

➔ **Eligible patients must not reside or be treated in Massachusetts where this offer is not valid**

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YERVOY Co-Pay Program *Terms and Conditions*

- The patient must pay the first $50 of co-pay for each infusion. This Program will cover the remaining out-of-pocket co-pay for up to 4 infusions of YERVOY and up to a maximum of $5000. Any costs exceeding the maximum of $5000 are the responsibility of the patient.
- This Program will cover the co-pay costs of YERVOY only. It does not cover the cost of the infusion or any other healthcare provider charges or any other treatment costs.
- The Program may apply to retroactive co-pays for outpatient infusions of YERVOY that occurred within 120 days prior to the date of enrollment, subject to the Program maximum of $5000.
- This offer is not valid for patients whose prescriptions are covered by a federal or state government-related healthcare program which pays in whole or in part for prescription drugs such as Medicare, Medicaid, TRICARE or VA Programs or where the entire cost of the prescription is covered by commercial insurance. Patients may not submit a claim for reimbursement under any of these programs.
- If you have commercial insurance, your acceptance of this offer confirms that the offer is consistent with your insurance and that you will report the value of the co-pay assistance you receive as may be required by your insurance provider. Patients must not seek reimbursement from any healthcare reimbursement accounts or flexible spending accounts. Patients who move from commercial to federally-funded insurance will no longer be eligible for the Program.
- Patients must enroll by December 31, 2011. Once a patient is enrolled in the program, the program will cover all doses (maximum of 4) in accordance with the FDA-approved YERVOY package insert.
- Explanation of Benefits (EOB) must be submitted within 180 days post-infusion to receive co-pay assistance.
- Proof required for payment must be a valid Explanation of Benefits (EOB) with YERVOY code-specific information. An EOB must be submitted regardless of assigned J Code.
- This offer is valid only in the United States and Puerto Rico.
- This offer is not valid for residents of Massachusetts or for infusions received in Massachusetts.
- This offer is not an insurance benefit.
- This offer is void where prohibited by law, taxed, or restricted.
- This offer may not be combined with any other offer, rebate, coupon, or free trial.
- This offer is non-transferrable.
- This is a limited time offer. Bristol-Myers Squibb reserves the right to rescind, revoke, amend, or terminate this offer or the program in its entirety at any time.

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HEALTHCARE PROFESSIONAL CERTIFICATION OF UNDERSTANDING OF THE YERVOY™ (ipilimumab) CO-PAY PROGRAM

Thank you for your interest in the Bristol-Myers Squibb YERVOY™ (ipilimumab) Co-Pay Program. As part of the Program, payment of up to $5000 of the patient's cost share for up to 4 infusions of YERVOY™ minus **a patient responsibility of $50 per infusion** will be paid directly to the healthcare provider for eligible dates of service on behalf of the patient.

Any funds previously paid as part of the patient's cost share for the product YERVOY™ for the dates of service covered under the YERVOY™ Co-Pay Program minus $50 per treatment must be paid directly back to the patient

If after the Program has paid the maximum amount of $5000 per patient for up to 4 infusions and there is an outstanding balance for any dates of service not covered under the Program, the doctor may hold the patient responsible for that remaining balance of valid cost share amounts.

Please sign and date below and fax back to Destination Access at **888-776-2370**. We will be unable to process the patient's request for assistance until your certification is received. If you have any questions please call BMS Destination Access at **800-861-0048**. We are available to answer your call Monday through Friday, from 8:00 am to 8:00 pm Eastern Time (excluding holidays).

Patient Name: <Patient Name>

Healthcare Provider Name: <Provider Name>

☑YES, Please enroll my patient in the Bristol-Myers Squibb YERVOY™ (ipilimumab) Co-Pay Program

CERTIFICATION

I certify that to the best of my knowledge, the patient referenced above satisfies the previously listed set of criteria and that I have read and agree to all of the terms and conditions of the program. I represent that the patient information I provided is consistent with applicable privacy laws and regulations, and I understand that Bristol-Myers Squibb and/or its agents are relying on this representation. I understand that the Bristol-Myers Squibb YERVOY Co-Pay Program or one of its agents may contact this office/site to verify information about this patient's treatment with YERVOY specific to this program.

I certify that 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 YERVOY administered to the patient. I certify that this office/site will comply with applicable obligations, if any, to disclose participation in this program to the applicable payers. I also certify that the bill or claim that this office/site will submit to the insurer or patient for payment for YERVOY will have YERVOY listed separately from any bill or claim for drug administration or any other items or services provided to the patient.

I further certify that no reimbursement of the cost of product will be accepted by me from the patient, for any treatment that is the subject of payment from the Bristol-Myers Squibb YERVOY™ Co-Pay Program. If funds have already been received from the patient for their share of the cost of YERVOY™ (minus $50 per treatment) for any dates of service paid through the YERVOY™ Co-pay Program, I will ensure payment is made back to the patient.

➲ **Please check the appropriate box below:**

☐ **The patient's share of cost of YERVOY™ is unpaid.** ***(Payment is not more than $50 per infusion, if applicable.)*** **Please send the amount provided by the YERVOY™ Co-Pay Program directly to the physician at the address specified on the application**

☐ **The patient's share of cost YERVOY™ has been paid. Please send the amount provided by the YERVOY™ Co-Pay Program directly to the patient at the address specified on the application**

_____ _____

➲ **Prescribing Physician's Signature** **Date**

The Program reserves the right to not provide cost sharing assistance until an accurate and complete certification is received from the physician, along with any other required documentation.

FAX APPLICATION TO DESTINATION ACCESS AT 888-776-2370