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

P.O. Box 991
Somerville, NJ 08876
Phone: (800) 736-0003
Fax: (866) 694-2545

Dear Applicant,

Thank you for your interest in the Bristol-Myers Squibb Patient Assistance Foundation (BMSPAF) Oncology Patient Assistance Program. Enclosed you will find the application form you had requested.

To participate in our program, you must be living in the U.S., Puerto Rico or the U.S. Virgin Islands and you must not have prescription drug coverage or receive any benefits that help you pay for prescription drugs, such as: Medicaid, Medicare Part D, State sponsored prescription drug programs, employee, military, retirement, or pension program drug coverage. Please note that pharmacy discount cards or drug company patient assistance programs are not considered to be prescription drug coverage and if you participate in these programs you still may qualify for assistance.

It is important that you complete all requested information and sign where indicated. Incomplete applications will be returned.

PATIENT REQUIREMENTS:

- ✓ Complete and sign the Patient Information section.
- ✓ Attach a photocopy of the ANNUAL household income (Federal tax form (1040), social security income (SSA 1099), pensions, interest, child support).

INCOME ELIGIBILITY CRITERIA REQUIREMENTS:

Total household income must not exceed the income criteria listed below (amounts may change annually):

Persons in Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	$32,670	$40,800	$37,620
2	$44,130	$55,140	$50,790
3	$55,590	$69,480	$63,960
4	$67,050	$83,820	$77,130
5	$78,510	$98,160	$90,300
For each additional person, add	$11,460	$14,340	$13,170

HEALTHCARE PROVIDER REQUIREMENTS:

- ✓ Complete and sign the Healthcare Provider Information section. There is no need to include a prescription.
- ✓ **Provide your State License Number in order to process the application.**
- ✓ Include ALL product information, including product name, dose/strength, frequency, and planned treatment dates (IV meds only). ***For IV medications, if the patient is re-applying to the program, flow sheets documenting treatments given since the last shipment received through this program, must be submitted along with the application.***
- ✓ List a shipping address of an authorized healthcare facility. Product will not be shipped to a patient's home or to a P.O. Box.
- ✓ Complete the ENTIRE application. When requesting a change of dosage for an existing patient, please indicate "YES" on the "change in dose schedule" portion of the application and provide the new prescription instructions.

SUBMIT COMPLETED APPLICATION BY SELECTING ONE OF THE FOLLOWING OPTIONS:

- ✓ MAIL: BMSPAF Oncology Patient Assistance
  P.O. Box 991
  Somerville, NJ 08876
- ✓ FAX: (866) 694-2545 (Please DO NOT fax multiple submissions of the application.)

You will be notified by mail upon completion of our review and evaluation. Please note that program rules are subject to change without notice. If you have questions or need further assistance, please call (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.
ONCOLOGY PATIENT ASSISTANCE PROGRAM
P.O. Box 991 | Somerville, NJ 08876 | Phone: (800) 736-0003 | Fax: (866) 694-2545

PATIENT INFORMATION TO BE COMPLETED BY PATIENT OR LEGAL GUARDIAN

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

Street Address where you live: **City:** **State:** **Zip Code:**

Mailing Address (if different from above): **City:** **State:** **Zip Code:**

Social Security Number: **Gender: Male** ☐ **Female** ☐ **Phone number: ( )**

PATIENT ELIGIBILITY INFORMATION - ATTACH PROOF OF ANNUAL HOUSEHOLD INCOME (REQUIRED)

TOTAL ANNUAL HOUSEHOLD INCOME (include all Annual Income, Wages, Social Security, Pensions, Interest Earned on Savings, Disability, Child Support, etc.): **$** _____

**** If you have indicated no income ($0), your application may be subject to audit or request for additional documentation.***

Household Size (number of persons living in the home):

Do you have any public or private prescription drug coverage or are you in any benefit program that helps you pay for your Prescription Drugs? Yes ☐ **No** ☐

I attest that the above and attached information is complete and accurate. I authorize the release of information about me and my medical condition to the Bristol-Myers Squibb Patient Assistance Foundation (BMSPAF) and/or its agents to use and disclose for the assessment of my eligibility for, enrollment into, and administration of the BMSPAF Oncology Patient Assistance Program, which may include contacting and receiving medical information from my insurer, public funding programs, advocacy organizations, healthcare providers, or other persons or entities the BMSPAF may deem appropriate. 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 its agents agree not to disclose any information to any third party except as authorized by me herein or otherwise or as required or permitted by law. I understand that I have the right to revoke this authorization at any time by writing to the BMSPAF at the address set forth above. If I revoke this authorization, I will no longer be eligible for this program. I understand and acknowledge that this assistance is temporary and that this program may be changed or discontinued at any time without notice. I further certify that, with respect to any product provided under this program, I will not seek reimbursement or credit from any public or private prescription drug insurer.

Patient Signature: _____ **Date:** _____

HEALTHCARE PROVIDER INFORMATION TO BE COMPLETED BY THE PRESCRIBING PRACTITIONER

First Name: **Last Name:** **Professional Designation:**

State License Number:

Facility Name:

Shipping Address, if different from Mailing Address, below:

City: **State:** **Zip Code:**

Mailing Address:

City: **State:** **Zip Code:**

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

REQUESTED MEDICATION

Drug Name	Dose (mg or unit)	Frequency	IV Medications Only – Planned Outpatient Treatment Dates

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:** _____