Bristol-Myers Squibb

BARACLUDE PATIENT ASSISTANCE PROGRAM
6900 College Boulevard, Suite 1000
Overland Park, KS 66211
Phone: 855-898-0267 ◆ Fax: 855-286-6831

Thank you for your interest in the Bristol-Myers Squibb Patient Assistance Program for Baraclude® (entecavir). The Baraclude Patient Assistance Program provides free medication to qualified patients, who do not have prescription drug coverage or receive any benefits that help pay for prescription drugs, such as: Medicaid, Medicare Part D, state-sponsored prescription drug programs, employee, military, retirement, or pension drug coverage programs. Please note that pharmacy discount cards or drug company patient assistance programs are not considered to be prescription drug coverage programs.

SIMPLE 3-STEP REGISTRATION:

✓ STEP 1 - PATIENT SUBMISSION 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.

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

- Please attach a photocopy of the proof of the annual household adjusted gross income. Examples include: Federal tax return (1040) ***(preferred),*** social security income (SSA 1099), pensions, interest, retirement, child support, etc.
- Include **TOTAL ANNUAL 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).

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

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

✓ STEP 2 - HEALTHCARE PROVIDER SUBMISSION REQUIREMENTS:

- Complete all sections on Page 2 of the Healthcare Provider Enrollment Form.
- Provide both State License and DEA information.
- **Provide copies of insurance cards (front & back), enlarged, if possible.**
- **Sign and date the Enrollment Form**. Stamped signatures or signatures by persons other than the prescribing healthcare provider are not acceptable.

✓ STEP 3 - FAX OR MAIL APPLICATION FORM:

FAX #: (855) 286-6831

MAIL: Baraclude Patient Assistance Program
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, the Baraclude Patient Assistance Program will notify the patient and the patient's healthcare provider of the results and any additional assistance options which may be available. Should you have any questions, please call (855) 898-0267. Our customer service administrators are available between the hours of 8:00 AM and 8:00 PM Eastern Time, Monday through Friday (excluding holidays). Please note that Program rules are subject to change without notice.

Sincerely,
Bristol-Myers Squibb

Attachment

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CASE #: **DATE:**

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

PATIENT NAME (FIRST AND LAST): _____

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

STREET ADDRESS: _____

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

SOCIAL SECURITY # (provide if available)**:** _____

PATIENT CONTACT: _____ **RELATIONSHIP TO PATIENT:** _____ **CONTACT PHONE #:** _____

IF ENGLISH NOT SPOKEN, INDICATE PRIMARY LANGUAGE & DIALECT: _____

✓ PATIENT FINANCIAL INFORMATION: ** (Proof of income required only if applying for free product)*

 # PERSONS IN HOUSEHOLD: _____

TOTAL ANNUAL ADJUSTED GROSS INCOME FOR YOUR ENTIRE HOUSEHOLD *(before taxes)*: $_____

(Include all annual income, wages, pensions, 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 paystubs (one month), copy of social security check or awards letter, etc.

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

✓ PATIENT INSURANCE INFORMATION: *(please include a copy of insurance cards, front and back)*

Does the patient have any Prescription Drug Coverage? ☐ **YES** ☐ **NO**

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:** _____

List all Prescription Drug Plans information below, including Medicare Part D or Medicare Advantage, if applicable:

	INSURANCE NAME	PHONE #	ID/POLICY #	GROUP #	POLICY HOLDER
PRIMARY					
SECONDARY					
STATE PROGRAM					
VETERAN OR OTHER PLAN					

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

ADAP: ☐ **Not Applied** ☐ **Denied** ☐ **Pending Coverage** ☐ **Waitlist**

I certify that the information that I have provided on this enrollment form is true and complete. I authorize the release of the information contained on this enrollment form to BMS, its agents and the Baraclude Patient Assistance 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. **If I receive any free product from BMS, I certify that I will not seek reimbursement from any public or private prescription drug plan for the use of such product.**

Patient/Legal Guardian Signature: _____ Date: _____

This program is limited by available resources and is subject to immediate change or cancellation

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PATIENT NAME (FIRST AND LAST):

✓ PROVIDER INFORMATION: THIS PAGE TO BE COMPLETED BY THE 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 PRODUCT INFORMATION:

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

IS DOCTOR CONTRACTED WITH PATIENT INSURANCE? ☐ **YES** ☐ **NO**

PRODUCT REQUESTED	DOSE (MG OR UNIT)	FREQUENCY
BARACLUDE		

✓ BARACLUDE PATIENT ASSISTANCE PROGRAM CARD INFORMATION:

If you provided the patient with a Baraclude Patient Assistance Program card please provide the Member ID# from the front of the card. If the patient is approved for free drug assistance their card will be activated for use at the time of approval. ***Please note:*** *if no card was provided to the patient, the program will mail a Baraclude Patient Assistance Program card to the patient if the patient is approved into the program.*

BARACLUDE PATIENT ASSISTANCE PROGRAM CARD MEMBER ID #: _____

✓ FAX OR MAIL APPLICATION FORM:

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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 Baraclude 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, and that 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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