BRISTOL-MYERS SQUIBB PATIENT ASSISTANCE FOUNDATION, INC.
ORENCIA® (abatacept) 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) ORENCIA® (abatacept) 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, 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, and if you participate in these programs you still may qualify for assistance.

It is important that you and your healthcare provider complete all requested information and sign where indicated. Incomplete or incorrect information may delay the process, so please ensure all information is provided correctly and signatures are obtained.

PATIENT REQUIREMENTS:

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

INCOME ELIGIBILITY CRITERIA REQUIREMENTS:

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

Persons in Household	48 Contiguous States, D.C., Puerto Rico & U.S. Virgin Islands	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**
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 for an initial 4-week supply to be shipped upon approval. Subsequent shipments require completion of a separate Refill Request Form by the Healthcare Provider.
- ✓ ***If the patient is re-applying to the program for ORENCIA IV, the application must include the date(s) of treatment given since the last shipment received through this program.***
- ✓ Provide a valid shipping address where the medication should be shipped. Product cannot be shipped to a P.O. Box or outside of the U.S., Puerto Rico or the U.S. Virgin Islands.
- ✓ Complete the ENTIRE application.

SUBMIT COMPLETED APPLICATION BY SELECTING ONE OF THE FOLLOWING OPTIONS:

- ✓ MAIL: BMSPAF ORENCIA® (abatacept) 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.

ORENCIA® (abatacept) 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 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**

Do you have Medicare Coverage? ❑ **Yes** ❑ **No**

If Yes, check all that apply: ❑ **Part A** ❑ **Part B** ❑ **Part D** ❑ **Medicare Advantage**

PATIENT HEALTH INFORMATION

List all known allergies: ❑ **None** _____

_____

List all medications you are currently taking: ❑ **None** _____

_____

List any health conditions: _____

_____

Are you currently: ❑ **Pregnant** ❑ **Nursing Infant**

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 ORENCIA® (abatacept) 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:** _____

BRISTOL-MYERS SQUIBB PATIENT ASSISTANCE FOUNDATION, INC.
ORENCIA® (abatacept) PATIENT ASSISTANCE PROGRAM

Patient Name: _____

HEALTHCARE PROVIDER INFORMATION (to be completed by the prescribing practitioner)	**SHIPPING INFORMATION (please select shipping location and complete if shipping address is different from healthcare provider address or patient address)**
First Name: **Last Name:**	**SHIPPING LOCATION:** ❑ **Healthcare Provider** ❑ **Infusion Provider** ❑ **Patient**
State License #: **NPI #:**	**Preferred Delivery Day(s):** **Tues** **Weds** **Thurs** **Fri**
Facility Name:	**Facility/Practice or Patient Name:**
Mailing Address:	**State License #:** **DEA#:**
	Shipping Address:
City: **State:** **ZIP Code:**	**City:** **State:** **ZIP Code:**
Contact Name:	**Contact Name:**
Contact Phone: **Contact Fax:**	**Contact Phone:** **Contact Fax:**

Please select the requested initial 4-week supply and complete the section(s) corresponding to the letter(s) you choose†

†Subsequent shipments require completion of a separate Refill Request Form by the healthcare provider.

❑ **(A) ORENCIA IV - Initial Treatment**
❑ **(B) ORENCIA IV - Maintenance Treatment**
❑ **(C) ORENCIA Subcutaneous**
❑ **(A&C) ORENCIA IV Single Loading Dose & ORENCIA Subcutaneous**

Diagnosis (ICD-9 Code): **Description:**

PRESCRIBING INFORMATION – ORENCIA IV (intravenous – office administered)*

	PRODUCT REQUESTED	DOSE (mg)	FREQUENCY	PLANNED OUTPATIENT TREATMENT DATE(S)
A	ORENCIA IV (250 mg vial) Initial Treatment (Protocol)		❑ 0, 2, 4 weeks ❑ Single Loading Dose	
B	ORENCIA IV (250 mg vial) Maintenance Treatment			
	PRODUCT ADMINISTERED (complete if re-applying)	**DOSE (mg)**	**FREQUENCY**	**PREVIOUS TREATMENT DATE(S) (from flow sheets)****
	ORENCIA IV (250 mg vial)			

**ORENCIA IV may only be shipped to the healthcare provider's office or to the infusion provider.*

***Infusion Flow Sheets of previous treatments may be requested for auditing purposes, as a proof of administration of the product received through the BMSPAF ORENCIA Patient Assistance Program.*

PRESCRIBING INFORMATION – ORENCIA Subcutaneous (self-injectable)

	PRODUCT REQUESTED	DOSE (mg)	FREQUENCY	Supply (please check)
C	ORENCIA Subcutaneous (self-injectable) (125 mg/mL prefilled syringe)	125 mg/mL (1 syringe)	once weekly	❑ 4 syringes

SHIPPING SCHEDULE ***(calls made upon receipt of Refill Request Form to arrange for delivery, every four weeks)***

New Enrollees	Re-enrollees
• One year supply from approval date (with healthcare provider refill every 4 weeks) • Three shipments of a 4-week supply for the first 12 weeks to healthcare provider's office • Ten shipments of a 4-week supply for the remaining enrollment period to patient's home or to healthcare provider's office	• One year supply from approval date (with healthcare provider refill every 4 weeks) • Thirteen shipments of a 4-week supply to patient's home or to healthcare provider's office

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. I represent that treatment with ORENCIA is medically necessary for this patient. 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:** _____