PATIENT

PATIENT AUTHORIZATION AND AGREEMENT

The BMS Access Support® program is a support program by Bristol-Myers Squibb Company (BMS) that helps patients understand their insurance coverage and financial support options for BMS medications, such as co-pay and free medication assistance. BMS also screens for patient assistance from the Bristol-Myers Squibb Patient Assistance Foundation, Inc. (the Foundation), an independent nonprofit that provides free medication to qualifying patients. To participate in the BMS Access Support program or to apply for the Foundation program, these programs will need to receive, use, and disclose your personal information. Please read this authorization for BMS and the Foundation carefully, and contact BMS at 1-800-861-0048 if you have any questions. Once you have read and agreed to this form, fax your signed copy to 1-888-776-2370.

1. What information will be used and disclosed?

My personal information will be disclosed, including:

- Information on the BMS Access Support enrollment form
- My contact information and date of birth
- Social Security number (which is voluntary)
- Financial and income information
- Insurance benefit information
- Health records and information, including medications prescribed to me
- Genetic tests that identify the kind of illness that I have and/or medication indicated for my treatment

2. Who will disclose, receive, and use the information?

This authorization permits my caretakers, which includes my healthcare providers, pharmacists, health plans, and health insurers who provide services to me, as well as other people that I say can help me apply, to disclose my personal information to BMS, the Foundation, and their authorized agents and assignees (their "Administrators"). BMS and the Foundation and their Administrators may also share my information with my caretakers and with other healthcare providers, pharmacists, health insurers, and charitable organizations to determine if I am eligible for, or enrolled in, another plan or program.

3. What is the purpose for the use and disclosure?

My personal information will be used by and shared with the persons and organizations described in this authorization in order to:

- Process my application for both the BMS Access Support and Foundation programs
- Provide the BMS Access Support program services to me, including verifying my insurance benefits, researching insurance coverage options, and referring me to other plans or assistance programs that may be able to help me
- Provide co-pay assistance to me, if I am eligible
- Contact my caretakers and me about the programs and the services that are available
- Contact other healthcare providers and charitable organizations to determine if I am eligible for, or enrolled in, another plan or program
- Provide me with free medication through BMS or the Foundation, if I qualify
- Improve or develop the programs' services

4. When will this authorization expire?

This authorization will be effective for 5 years unless it expires earlier by law or I cancel it in writing. I may cancel this authorization for either or both programs by writing to:

BMS Access Support
P.O. Box 221509
Charlotte, NC 28222-1509

If I cancel this authorization for a program, I will no longer be able to participate in that program. That program will stop using or disclosing my information for the purposes listed in this authorization, except as necessary to end my participation or as required or allowed by law. **I understand that if I receive free medication, I must reapply at least every year, sign an authorization for both BMS Access Support and the Foundation, and be accepted.**

(continued on next page)

! PATIENT OR PERSONAL REPRESENTATIVE INITIALS _____

PATIENT

PATIENT AUTHORIZATION AND AGREEMENT (cont.)

5. Notices: I understand that once my health information has been disclosed, privacy laws may no longer restrict its use or disclosure. BMS, the Foundation, and their Administrators agree to use and disclose my information only for the purposes described in this authorization or as allowed or required by law. I further understand that I may refuse to sign this authorization and that if I refuse, my eligibility for health plan benefits and treatment by my healthcare providers will not change, but I will not have access to the BMS Access Support® or Foundation programs. I have a right to receive a copy of this authorization after I have signed it.

6. Authorization for a Consumer Report (for patients applying or referred to the Foundation program): I authorize the Foundation and its Administrators to obtain a consumer report on me. My consumer report, and information derived from public and other sources, will be used to estimate my income as part of the process to determine if I am eligible to receive free medication from the Foundation. Upon request, the Foundation will provide me the name and address of the consumer reporting agency that provides the consumer report. I may call the Foundation at 1-800-736-0003 for this information.

7. Patient certifications: I certify that the personal information that I provide to BMS and the Foundation is true and complete. I agree that, at any time during my participation in either or both programs, BMS (and the Foundation, if applicable) may request additional documentation to verify my personal information. If there is missing information or I do not respond to requests for additional documents, my participation may be delayed or I may no longer be able to participate. If I qualify for and receive co-pay assistance or free medication assistance from BMS, I agree to comply with BMS' program rules and I will not get reimbursed for the assistance I receive from anyone else, including from an insurance program, another charity, or from a health savings, flexible spending, or other health reimbursement account. I understand that assistance may be temporary and that I may be required to apply every year. I will contact BMS Access Support at 1-800-861-0048 if my insurance or treatment changes in any way.

If I qualify for and receive free medication from the Foundation program, I agree to comply with the Foundation's program rules; and I will not get reimbursed for the assistance I receive from anyone else, including from an insurance program, another charity, or from a health savings, flexible spending, or other health reimbursement account. If I have Medicare Part D, I will also not count any free medication I receive towards my true out-of-pocket costs (TrOOP). I understand that the Foundation's help is temporary, I must reapply every year, and I may not be eligible if I have prescription drug coverage that will pay for my medication. I agree to immediately contact the Foundation at 1-800-736-0003 if my insurance, treatment, or financial situation changes in any way.

I understand that the BMS Access Support and the Foundation programs may be discontinued or the rules for participation may change at any time, without notice.

I HAVE READ THIS AUTHORIZATION AND AGREE TO ITS TERMS:

Print Name of Patient or Personal Representative:

Description of Personal Representative's Authority:

Preferred Email Address: Zip:

Patient Date of Birth: Initials:

! SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE Date:

The patient or his/her personal representative must be provided with a copy of both pages of this form after it has been signed.

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