Bristol-Myers Squibb
access|support

Kidney Transplant Access and Reimbursement Support

1-800-861-0048 1-888-776-2370 FAX

Simple Steps to Enroll

Physician

- ☐ Complete the Services and Treatment sections on page 1
- ☐ Complete the Physician Information section on page 2
- ☐ Read, sign, and date Physician Certification on page 2

Patient

- ☐ Complete the Patient Information section on page 3
- ☐ If enrollment into the BMS Kidney Transplant Co-Pay Assistance Program is requested, please read the Program Terms and Conditions on page 4
- ☐ Read, sign, and date Patient Authorization and Agreement (PAA) on page 6 (initial page 5)

FAX completed and signed enrollment form to BMS Access Support® at 1-888-776-2370

What to Expect After Enrollment

Physician

Your BMS Access Support representative will:

- Provide benefits review results within 24 hours (within one business day upon receipt of a completed enrollment form)
- If requested, provide identification of potential infusion provider results

Patient

- Your physician's office will inform you of the results of the benefit review when received
- If co-pay assistance is requested, you will receive a letter informing you of eligibility if accepted

Thank you for taking the time to complete this enrollment form.
If you have any questions, please contact BMS Access Support at 1-800-861-0048.

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Services – to be completed by Physician

Services Requested (Please choose all services desired.)

- ☐ Benefit Review, Prior Authorization, Appeals Assistance
- ☐ BMS Kidney Transplant Co-Pay Assistance Program
- ☐ Identification of Potential Infusion Providers

BMS cannot guarantee acceptance by any program.

Treatment – to be completed by Physician

Medication Prescribed

☑ NULOJIX® (belatacept)

Treatment Information

Patient Diagnosis: ICD Code _____ Description _____

Transplant Center Information

Transplant Center Name _____

Street Address _____ City _____ State _____ Zip _____

Contact Name _____ Contact Role _____

Contact Phone _____ Contact Fax _____

Transplant Physician Name _____ TAX ID of Transplant Center _____

Referring Physician Information (HCP who referred patient to the transplant center)

Referring Physician Name _____ Specialty _____

Street Address _____ City _____ State _____ Zip _____

Office Phone _____ Fax _____

Post-Transplant Physician Information – to be completed by Physician responsible for post-transplant patient care

Treating Physician Name _____
First name Last name

Treating Physician Specialty _____

Street Address _____ City _____ State _____ Zip _____

Office Phone _____ Fax _____

Physician Tax ID # _____ Physician NPI # _____

Is HCP above administering NULOJIX® (belatacept) to this patient? ☐ Yes ☐ No If no, please complete the information below

Infusion Site Name _____ NPI # _____

Street Address _____ City _____ State _____ Zip _____

Site Contact Name _____ Contact Role _____

Contact Phone _____ Contact Fax _____

If identification of potential infusion sites is requested, indicate the date an alternate infusion site is needed _____

Physician Certification – to be completed by Physician

I certify to the following: (1) To the best of my knowledge, the patient and physician information in this form is complete and accurate; **(2)** I have the authority to disclose this patient's information to BMS and its respective agents and assignees, and I have obtained this patient's authorization for the disclosure, if required by HIPAA or other applicable privacy laws; and **(3)** I have determined based on my professional judgment that the kidney transplant medication prescribed is medically necessary.

I certify, if the patient enrolls in the BMS Access Support Kidney Transplant Co-Pay Assistance Program, to the following:

- I have read and will comply with the Program Terms and Conditions on page 4
- To the best of my knowledge, this patient satisfies the Patient Eligibility requirements, and I will notify the Program immediately if the patient's insurance status changes
- 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 the covered BMS medication(s) administered to the patient
- The bill or claim that this office/site will submit to the insurer or patient for payment for BMS medication(s) will have the BMS medication(s) listed separately from any bill or claim for drug administration or any other items or services provided to the patient
- I will not submit an insurance claim or other claim for payment to any third-party payer (private or government) for the amount of assistance that my patient receives from the Program

I understand that BMS (1) may verify all information provided, and not allow or suspend participation if inadequate information is received; (2) may modify, limit, or terminate these programs, or recall or discontinue medications, at any time without notice; and (3) are relying on these certifications.

SIGNATURE _____ Date ____ / ____ / _____

Physician or Licensed Prescriber signature (required—no stamps)

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Patient Information – to be completed by Patient

Personal Information

Patient name _____ ☐ Male ☐ Female Birth Date: ____ / ____ / ____
First name Last name

Address _____ City _____ State _____ Zip _____

Home phone _____ Mobile _____

Insurance Information

Do you have insurance through: (please check all that apply)
☐ Private/Employer-based insurance ☐ VA or military ☐ State assistance program for medication ☐ Medicaid
Medicare – ☐ Part A ☐ Part B ☐ Part D ☐ Medicare Advantage ☐ None

Primary insurance carrier _____ Primary insurance policy # _____

Phone _____ Group # _____ Policy holder _____

Secondary insurance carrier _____ Secondary insurance policy # _____

Phone _____ Group # _____ Policy holder _____

State, Veteran, or Other Prescription Coverage _____ Prescription Policy # _____

Phone _____ Group # _____ Policy holder _____

If you chose Medicaid or Veteran status above, please choose applicable options below.

Medicaid Status ☐ Not Applied ☐ Denied ☐ Application Pending

Veteran Status ☐ Yes ☐ No **Applied for VA** ☐ Yes ☐ No

BMS Access Support® Kidney Transplant Co-Pay Assistance Program Terms & Conditions

The BMS Kidney Transplant Co-Pay Assistance Program is designed to assist eligible commercially insured patients who have been prescribed a BMS kidney transplant medication with out-of-pocket deductibles, co-pay, or co-insurance requirements.

Patient Eligibility:

- You have commercial (private) insurance that covers your prescribed Bristol-Myers Squibb (BMS) medication, but your insurance does not cover the full cost; that is, you have a co-pay obligation (out-of-pocket cost) for your prescribed medication.
- You are an adult kidney transplant patient being treated with a BMS kidney transplant medication for prevention of kidney rejection.
- You are not participating in any state or federal healthcare program including Medicaid, Medicare, Medigap, CHAMPUS, TriCare, Veterans Affairs (VA), or Department of Defense (DoD), or any state, patient, or pharmaceutical assistance program. Patients who move from commercial (private) insurance to a state or federal healthcare program will no longer be eligible. If you purchased your prescription insurance through a Health Exchange (also known as a Health Insurance Marketplace or Small Business Health Options Program [SHOP] Marketplace), you are currently eligible.
- You live in the United States or Puerto Rico.

Program Benefits:

- You must pay the first $50 of the co-pay for each dose of a BMS medication covered by this Program. This Program will cover the remainder of the co-pay, up to a maximum of $7,000 during a calendar year. Patients are responsible for any costs that exceed the Program's $7,000 maximum.
- In order to receive the Program benefits, the patient or provider must submit an Explanation of Benefits (EOB) form, or a Remittance Advice (RA). The submitted form must include the name of the insurer, plan information, and show that the BMS medication supported by this Program was the medication that was given. The form must be submitted within 180 days of receiving each dose.
- The Program may apply to retroactive out-of-pocket expenses that occurred within 120 days prior to the date of the enrollment. These benefits are subject to the $50 patient co-pay requirement and the 12-month Program maximum of $7,000.
- The Program benefits are limited to the co-pay costs for BMS medications covered by this Program that the patient receives as an outpatient. The Program will not cover, and shall not be applied toward, the cost of any dosing procedure, any other healthcare provider service or supply charges or other treatment costs, or any costs associated with a hospital stay.
- Program payments are for the benefit of the patient only.

Program Timing:

- The enrollment period is 1 calendar year.
- Patients must enroll by December 31, 2019.
- Absent a change in Massachusetts law, effective July 1, 2019, Massachusetts residents will no longer be able to participate in this Program.

Additional Terms and Conditions of Program:

- Patients, pharmacists, and healthcare providers must not seek reimbursement from health insurance or any third party for any part of the benefit received by the patient through this Program. Patients must not seek reimbursement from any health savings, flexible spending, or other healthcare reimbursement accounts for the amount of assistance received from the Program.
- Acceptance of this offer confirms that this offer is consistent with patient's insurance. Patients, pharmacists, and healthcare providers must report the receipt of co-pay assistance benefits as may be required by patient's insurance provider.
- This offer is not valid with any other program, discount, or incentive involving a BMS medication eligible for this Program.
- Only valid in the United States and Puerto Rico; this offer is void where prohibited by law, taxed, or restricted.
- The Program benefits are nontransferable.
- No membership fees.
- This offer is not conditioned on any past, present, or future purchase, including additional doses.
- **The Program is Not Insurance.**
- Bristol-Myers Squibb reserves the right to rescind, revoke, or amend this offer at any time without notice.

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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. To participate in the BMS Access Support Program, the Program will need to receive, use, and disclose your personal information. Please read this authorization 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
- Financial and income information
- Insurance benefits information
- Health records and information, including medications prescribed to me

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, and its authorized agent and assignees (their "Administrators"). BMS and its 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 the BMS Access Support Program
- Provide the BMS Access Support Program services to me, including verifying my insurance benefits, researching insurance coverage options, locating sites of care where I can receive treatment, 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
- 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, I will no longer be able to participate in the program. The 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.

(continued on next page)

Patient or Personal Representative Initials _____

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Patient Authorization and Agreement (cont'd)

5. Notices:

I understand that once my health information has been disclosed, privacy laws may no longer restrict its use or disclosure. BMS and its 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 program. I have a right to receive a copy of this authorization after I have signed it.

6. Patient certifications:

I certify that the personal information that I provide to the BMS Access Support Program is true and complete. I agree that, at any time during my participation in the program, the program 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 from the program, I agree to comply with the program Terms and Conditions 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 will contact BMS Access Support at 1-800-861-0048 if my insurance or treatment changes in any way.

I understand that the BMS Access Support Program 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 E-mail Address _____

Zip Code _____ 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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