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. To participate in the BMS Access Support program, this 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 1-866-268-5385.

1. What information will be used and disclosed?

My personal information will be disclosed, including:

- Information on this application 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

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 agents and assignees (its "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, 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 by writing to:

BMS Access Support
P.O. Box 220745
Charlotte, NC 28222-0745

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.

(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 BMS Access Support 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 BMS is true and complete. I agree that, at any time during my participation in BMS Access Support, BMS 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 BMS, 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 _____ 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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