Bristol-Myers Squibb

BMS3assist
P.O. Box 221430, Charlotte, NC 28222-1430
888-281-8981 • Fax: 888-281-8985

The **BMS3assist Program** is designed to help patients with reimbursement needs for certain Bristol-Myers Squibb (BMS) medications. The Program assists patients and their healthcare providers with the following services:

- Insurance benefit investigations
- Prior authorization and/or insurance appeal support
- Referrals to independent, non-profit co-pay foundations that help patients who have coverage for their medications but need help paying for their out-of-pocket costs for treatment
- Free medications to qualified patients who do not have prescription drug coverage and are having a hard time paying for medication. Patients may be eligible if they:
  - Are being treated as an outpatient;
  - Live in the USA, Puerto Rico, or the U.S. Virgin Islands;
  - Meet the income limits for the requested medication;
  - Do not have insurance coverage OR they are enrolled in a Medicare Part D plan that covers the medication and have spent at least 3% of their yearly household income on out-of-pocket costs for prescription medications this year;
    - You can request a report from your pharmacy that shows your out-of-pocket costs (co-pays) for this year
    - You can submit that report with your application

These are just some of the eligibility requirements – meeting these criteria does not guarantee acceptance.

Patients who are accepted into the patient assistance program may be able to receive their first dose via overnight delivery to the patient's residence or the healthcare provider. Remaining shipments will be sent 2-day ground.

THE MEDICATIONS THAT THE BMS3ASSIST PROGRAM HELPS WITH ARE:

- Evotaz® (atazanavir and cobicistat)
- Reyataz® (atazanavir)
- Sustiva® (efavirenz)

HOW DO I APPLY?

Complete this application. Be sure to check off which service you are requesting.
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.

Fax or Mail Application

FAX #: (888) 281-8985

MAIL: BMS3assist
P.O. Box 221430
Charlotte, NC 28222-1430

Once the Program receives your completed application, the Program will process it and notify the healthcare provider of the results. Incomplete or incorrect information may delay the process, so please ensure all information is provided correctly and signatures are obtained.

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

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CASE # (FOR BMS INTERNAL USE ONLY):

THIS PAGE TO BE COMPLETED BY THE PATIENT

PATIENT INFORMATION

(Please print or type)

Patient Name (First, Last and any Suffix):	Social Security # (providing Social Security Number is optional):	
Date of Birth:	Gender: ☐ Female ☐ Male	
Patient Address:		
City:	State:	ZIP:
Home Phone:	Cell Phone:	Best Time to Call:
Alternate Contact Name/Patient Advocate:	Relationship:	Phone:

PATIENT INSURANCE INFORMATION

☐ **Medicaid**	☐ **Medicare A or B**	☐ **Medicare Part D**	☐ **None**
☐ **VA Military**	☐ **Private Insurance**	☐ **ADAP**	

☐ **Insurance Card, FRONT and BACK to be included in the application submission**

Insurance Name	Phone #	ID/Policy #	Group #	Policy Holder
Primary:				
Secondary:				

PATIENT MEDICATION AND FINANCIAL INFORMATION (complete only if applying for free medication)

Allergies:	Medications Currently Taking:	
# ADULTS IN HOUSEHOLD (include yourself in the total #):	**# CHILDREN (UNDER 18) IN HOUSEHOLD:**	**TOTAL ANNUAL ADJUSTED GROSS INCOME FOR YOUR ENTIRE HOUSEHOLD** (before taxes): $

If you have a Medicare Part D plan & have spent 3% of your annual income on out-of-pocket prescription costs, please provide proof of those expenses. Your pharmacy can provide you with a report that shows what you have spent.

BMS3assist may request proof of income.

Patient Authorization and Agreement

The BMS3assist 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. Please read this Authorization carefully. Fax your signed copy to 1-888-281-8985.

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
- Information about my HIV status and treatment

2) Who will disclose, receive, and use the information? This authorization

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Patient Authorization and Agreement *(continued)*

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 ("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 BMS3assist Program
- Provide the BMS3assist 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
- Contact my caretakers and me about the Program 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 the Program, if I qualify
- Improve or develop the Program's services

4) When will this authorization expire? This authorization will be effective for 2 years unless it expires earlier by law or I cancel it in writing. I may cancel this authorization by writing to:

BMS3assist
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. I understand that if I want to receive free medications, I must reapply at least every year and be accepted.

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 BMS3assist Program. 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 for free medication)
I authorize BMS and its Administrators to obtain a consumer report on me. My

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Patient Authorization and Agreement *(continued)*

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 BMS3assist Program. Upon request, the Program will provide me the name and address of the consumer reporting agency that provides the consumer report. I may call the BMS3assist Program at 1-888-281-8981 for this information.

7) Patient Certifications

I certify that the personal information that I provide to the BMS3assist Program is true and complete.

I agree that, at any time during my participation in the BMS3assist 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, the Program may delay my participation or decide I can no longer participate.

If I qualify for and receive free medication from the BMS3assist Program, I agree that I will not get reimbursed for it 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 help with getting free medication 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 BMS3assist Program at 1-888-281-8981 if my insurance or financial situation changes in any way.

I understand that the BMS3assist Program may be discontinued or the rules for participation may change at any time, without notice.

SIGNATURE

I have read this authorization and agree to its terms:

Print name of Patient or Personal Representative:

Description of Personal Representative's Authority:

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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Patient Name: | **CASE #** (For BMS Internal Use Only):

THIS PAGE TO BE COMPLETED BY THE PROVIDER

PROVIDER INFORMATION (Please print or type)

Services Provided:	☐ Benefits Verification	☐ Appeals Assistance	☐ Prior Authorization	☐ Patient Assistance
Physician Name:		NPI #:	
State License #:		Tax ID #:	
Facility Name:		Phone:	
Mailing Address:			
City:		State:	ZIP:
Primary Contact Name:		Title:	
Phone:	Ext:	Fax:	

DIAGNOSIS AND PRODUCT INFORMATION

PATIENT DIAGNOSIS:	ICD Code:	DESCRIPTION:

MEDICATION	DOSE	FREQUENCY	NUMBERS OF REFILLS

If applying for Patient Assistance, prescriptions may be written for up to a 1-year supply, subject to eligibility period limits. Specify the number of refills needed. Up to a 90-day supply is available per shipment.

SHIPPING INFORMATION

*INFORMATION REQUIRED IN THIS SECTION ONLY IF APPLYING FOR FREE MEDICATIONS

MEDICATION will be shipped to? ☐ **Physician's Office** ☐ **Patient's Residence**

Complete the section below if you selected Physician's Office and shipping information is different from above:

Shipping Facility Name (if different from above): Do **NOT** provide a P.O. Box for the street address.

Shipping Address:

City:	State:	ZIP

State License # of the Shipping Address Location (if different from above)

Incomplete or incorrect information may delay the process, so please ensure all information is provided correctly and signatures are obtained.

PROVIDER CERTIFICATION: I certify to the following: (1) To the best of my knowledge, the information provided to the Program, and 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 if required by HIPAA or other applicable privacy laws; (3) I have prescribed the medication to this patient based on my professional judgment of medical necessity; (4) If this patient receives free medication from the Program, to the best of my knowledge, this patient has no prescription insurance coverage (including Medicaid, Medicare, or other public or private programs), or is unable to afford the cost-sharing requirements associated with his/her insurance coverage for this medication; (5) I will immediately notify the Program if my patient receives free medication and I become aware that his/her insurance or income status has changed; (6) I will not submit an insurance claim or other claim for payment to anyone else including a third-party payer (private or government) or the patient, and I will forego any appeal of any denial of insurance coverage, for free medication provided by the Program for this patient; (7) Any medication provided by the Program for this patient will be used only for this patient and will not be resold, nor offered for sale, trade or barter, or returned for credit.

I understand that BMS and its agents and assignees: (1) Reserve the right to verify all information provided by providers, suspend participation where inadequate information is provided, and limit enrollment based on available resources; (2) Reserve the right to modify or terminate the Program, or recall or discontinue medications, at any time without notice; (3) Are relying on the certifications in this form. I authorize this prescription.

Physician Signature:	Date:

Physician or Licensed Prescriber Signature (required - no stamps)