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 not have prescription drug coverage or receive any benefits that help you pay for prescription drugs, such as: Medicaid, Medicare Part D, State sponsored prescription drug programs, employee, military, retirement, or pension program drug coverage. 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 complete all requested information and sign where indicated. Incomplete or incorrect applications will delay the application process so please ensure all information provided is correct.

PATIENT SUBMISSION REQUIREMENTS:

- ✓ Complete and sign the Patient Information section
- ✓ Attach a photocopy of the ANNUAL household income. (Federal tax form (1040), Request for Transcript of Tax Return (Verification of non-filing form 4506-T), social security income (SSA 1099), pensions, interest, retirement, child support, letter from healthcare professional, shelter or patient advocate, Healthcare Provider (clinic, shelter etc.) income pre-certification statement).

HEALTHCARE PROVIDER REQUIREMENTS:

- ✓ Complete and sign the Healthcare Provider Information section
- ✓ Please provide DEA# or copy of State License.
- ✓ Include ALL product information, including product name, dose/strength, frequency, and planned treatment dates. ***If patient is reapplying to the program, or requesting a refill, flow sheets documenting treatments administered since the last shipment through this program must be submitted along with the application or Refill Request Form.***
- ✓ List a shipping address of an authorized healthcare facility. Product will not be shipped to a patient's home or to a P.O. Box.
- ✓ Please do not attach a prescription to the application form.
- ✓ 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.)

We recommend that you fax the completed form in order to expedite the process. Once the application is received, eligibility will be evaluated for participation in the BMSPAF ORENCIA® (abatacept) Patient Assistance Program. Healthcare providers will be notified upon completion of eligibility review. 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

BMSPAF.org

Reset Form

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: THIS SECTION TO BE COMPLETED BY PATIENT

First Name: **MI:** **Last Name:** **Date of Birth:** / /

Mailing Address: **Apt #:**

City: **State:** **Zip Code:**

Social Security Number: **Gender: Male** ☐ **Female** ☐ **Phone number: ( )**

Enter number of people in household: **Is patient a U.S. Citizen or legal U.S. resident? Yes** ☐ **No** ☐

ATTACH PROOF OF ANNUAL HOUSEHOLD INCOME (REQUIRED)

Total Annual Income before taxes, for your entire household: **Including all Income, Wages, Social Security, Pensions, Interest, Disability, Retirement, Child Support, Savings, etc.:** $

Did you file a Federal Tax Return for the most current tax year? Yes ☐ **No** ☐

If no, sign below if you agree to allow the IRS to confirm to the Bristol-Myers Squibb Patient Assistance Foundation that you did not file a Federal tax return for the most current tax year.

Patient Signature for Application: _____ **Date:** _____

PLEASE NOTE: The IRS does not manage the use of this information for determining enrollment in the Bristol-Myers Squibb Patient Assistance Foundation. In addition, the IRS may contact you regarding your request. IRS: Please send verification to the address listed at the top of the application.

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** ☐

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:** _____

HEALTHCARE PROVIDER INFORMATION: THIS SECTION TO BE COMPLETED BY THE PRESCRIBING PRACTITIONER

First Name: **Last Name:** **DEA #:** **State License #:** (**Please provide copy of State License**)	**Shipping Address, if different from mailing address** ☐ **Healthcare Provider** ☐ **Infusion Provider**
Facility Name:	**Facility Name:**
Mailing Address:	**Shipping Address:**
City: **State:** **Zip Code:**	**City:** **State:** **Zip Code:**
Contact Name:	**Contact Name:**
Contact Phone: **Contact Fax:**	**Contact Phone:** **Contact Fax:**

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

PRODUCT REQUESTED	DOSE (mg or unit)	FREQUENCY	PLANNED OUTPATIENT TREATMENT DATES
Orencia Initial Treatment (Protocol)	**0, 2, 4 weeks**		
Orencia Maintenance Treatment			

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. 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:** _____