Thank you for downloading this patient assistance document from NeedyMeds. We hope this program will help you get the medicine you need.

REMEMBER - Send your completed application to address on the form, NOT to NeedyMeds.

Did you know that NeedyMeds has thousands of other free resources?

Here's a look at more ways we can help you save money on medicine and healthcare costs. Each one can be found under the **"Patient Savings"** tab on our website:

- **Diagnosis-Based Assistance** — NeedyMeds lists thousands of assistance programs for almost any health condition. If you are going through chemo treatment for cancer, there are programs that can help with wig costs and scalp-cooling products. We also list resources for free diabetes testing supplies, caregiver lodging support, and much more.

- **Free, Low Cost, and Sliding Scale Clinics** — This popular collection contains information on 18,000+ free, low cost, and sliding scale medical and dental clinics across the U.S. It's a great resource if you need affordable medical treatment and don't know where to go.

- **Coupons, Rebates & More** — You can use the NeedyMeds website to find nearly 2,000 cost-saving opportunities for both prescription and over-the-counter drugs and medical supplies.

- **Medical Transportation** — Need help getting to the doctor's office or medical facility? You may be eligible for financial assistance if you meet certain requirements.

Finally, I want to tell you about the NeedyMeds Drug Discount Card. Thousands of people use this free, anonymous, and easy-to-use tool to get the best price on their medications. To date, our drug discount card has saved patients over $244,000,000. Check out the next page to learn more.

Feel free to call our toll-free helpline if you have any questions. You can reach us at 1-800-503-6897 Monday-Friday, 9am-5pm Eastern Time.

Thanks for using NeedyMeds! Please let us know if we can do anything else to help you afford the costs of your healthcare.

Richard J. Sagall, MD
President, NeedyMeds

Clip the card and save

NeedyMeds
NeedyMeds.org

DRUG DISCOUNT CARD

BIN: 020750
RX PCN: NMeds
RX GRP: PDFPDF
ID: NMNA019309901930

Customer Care
1-888-602-2978

This is a drug discount program, not an insurance plan.

NeedyMeds Drug Discount Card
www.needymeds.org

Patient: You may use this card at any of over 65,000 participating pharmacies to save on all prescription medicines. You cannot use this card with Medicare including part D, Medicaid, or any other state or federal programs unless you choose not to use your government-sponsored program. In addition, you cannot use this card with any health insurance program, but you can use it in place of your insurance if the card offers a better price. For questions call 1-888-602-2978 or visit www.drugdiscountcardinfo.com.

Pharmacist: Administered by Medical Security Company, LLC, Tucson, AZ.

Pharmacy Help Desk: 1-800-404-1031.

Powered by ScriptSave® WellRx

- Save up to 80% on medications*
- Use at over 65,000 pharmacies nationwide including all major chains
- Share the card with friends and family
- Use the card as often as needed
- Free, no fees or registration
- Never expires

What will receive a discount?

All prescription medications are eligible for savings, including over-the-counter medicines and medical supplies written as a prescription, as well as human-equivalent pet medications with a prescription by a veterinarian.

You can also save up to 40% off durable medical equipment, including canes, crutches, splints, incontinence supplies and more. You can also save on diabetic supplies such as glucose meters, test strips, lancets and diabetic shoes. Visit www.needymeds.org/dme to learn more.

What if I have insurance?

Anyone can use the card, but it can't be combined with state or federal insurance. You can use the card instead of insurance if:

- A drug isn't covered by your insurance
- Your insurance has no drug coverage
- You have a high drug deductible
- You have met a low medicine cap
- The card offers a better price than your copay
- You are in the Medicare Part D donut hole

To obtain a plastic drug discount card, send a self-addressed, stamped envelope to:

NeedyMeds Drug Discount Card
PO Box 219
Gloucester, MA 01931

The card is not valid in combination with insurance plans, including Medicare, Medicaid or any state or federal prescription insurance. The card can be used only if you decide not to use your government-sponsored drug plan for your purchases.

* Average savings of 60%, with potential savings of up to 80% or more (based on 2018 national program savings data). All prescription medications are eligible for savings.

This is a drug discount program, not an insurance plan. Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the type of prescription and the pharmacy chosen. This program does not make payments directly to pharmacies. Users are required to pay for all prescription purchases. Cannot be used in conjunction with insurance. You may call 1-888-602-2978 with questions or concerns or to obtain further information.

Bristol-Myers Squibb

BARACLUDE PATIENT ASSISTANCE PROGRAM
P.O. Box 221430
Charlotte, NC 28222-1430
Phone: 855-898-0267 • Fax: 855-286-6831

BARACLUDE® PATIENT ASSISTANCE PROGRAM

The **Baraclude Patient Assistance Program** is designed to provide free medication to qualifying patients who do not have prescription drug coverage and are having a hard time paying for Baraclude (entecavir).

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 Program
- 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.

HOW DO I APPLY?

Complete this application.

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 #: 855-286-6831

MAIL: Baraclude Patient Assistance Program
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

Reset Form

Bristol-Myers Squibb

BARACLUDE (entecavir) PATIENT ASSISTANCE PROGRAM

855-898-0267 • Fax: 855-286-6831

CASE # (FOR BMS INTERNAL USE ONLY):

THIS SECTION 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 Name	Phone #	ID/Policy #	Group #	Policy Holder
Primary:				
Secondary:				

PATIENT MEDICATION AND FINANCIAL INFORMATION

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.

The Baraclude Patient Assistance Program may request proof of income.

Patient Authorization and Agreement

The Baraclude Patient Assistance Program is a program by Bristol-Myers Squibb Company (BMS) that provides free medication to qualifying patients who do not have prescription drug coverage and are having a hard time paying for Baraclude. To apply for this Program, patients must complete the Program application, including this Authorization. Please read this Authorization carefully and fax your signed copy, along with your application, to 1-855-286-6831.

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 infections and medications prescribed to me

(continued on next page)

Patient Authorization and Agreement *(continued)*

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 ("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 Baraclude Patient Assistance Program and verify my insurance benefits
- Provide me with the Program's services and free medication, if I qualify
- 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
- Improve or develop the Program's services

4) When will this authorization expire? This authorization will be effective for 1 year unless it expires earlier by law or I cancel it in writing. I may cancel this authorization by writing to:

Baraclude Patient Assistance Program
P.O. Box 221430
Charlotte, NC 28222-1430

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.

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) Authorization for a Consumer Report. I authorize BMS and its Administrators to obtain a consumer report on me. My consumer report, and

Print Patient's Name:	Date

(continued on next page)

Patient Authorization and Agreement *(continued)*

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 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 Program at 1-855-898-0267 for this information.

7) Patient Certifications. I certify that the personal information that I provide to the 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, the Program may delay my participation or decide I can no longer participate.

If I qualify for and receive free medication from the 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 Program at 1-855-898-0267 if my insurance or financial situation changes in any way.

I understand that the 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 all pages of this form after it has been signed.

Bristol-Myers Squibb

BARACLUDE (entecavir) PATIENT ASSISTANCE PROGRAM

855-898-0267 • Fax: 855-286-6831

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

THIS SECTION TO BE COMPLETED BY THE PROVIDER

PROVIDER INFORMATION

(Please print or type)

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

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

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 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)