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

REMEMBER — Send your completed application to the 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 **"Healthcare 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, dental, mental health and substance abuse 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 2,600+ 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.

NeedyMeds also offers information on diagnosis-based camps and retreats, recreational programs, scholarships, government programs, $4 generic drug programs, and more.

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. Use the card to get discounts on lab tests and also to save 40% on durable medical equipment. To date, our drug discount card has saved patients over $300,000,000. Check out the following page to learn more.

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

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

Rich 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.

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.

You can also save an extra 5% on affordable lab tests and online results. No doctor's order or insurance needed. Visit www.needymeds.org/L2L for more information.

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
50 Whittemore St.
Gloucester, MA 01930

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.

Reset Form

Bristol Myers Squibb™
Access Support®

Oncology Access and Reimbursement Support

PHONE: 1-800-861-0048 | **FAX:** 1-800-822-2496

Patient Name: _____ **Date of Birth:** _____

PHYSICIAN

SERVICES–to be completed by Physician

Services Requested (Please choose all services desired)

- ☐ **Benefits Review, Prior Authorization, Appeals Assistance**
- ☐ **BMS Access Support Co-Pay Assistance Program**
- ☐ **Referral to BMS Patient Assistance Foundation (BMSPAF)**
  BMSPAF is an independent, nonprofit organization that helps eligible patients get free medication. Visit BMSPAF.org for eligibility requirements.
- ☐ **Benefits Review of Specialty Pharmacy**
  Preferred Specialty Pharmacy:
  _____
- ☐ **Alternative Coverage or Support Research**
  (eg, independent charitable foundation referral)

! *BMS cannot guarantee acceptance by any program or foundation.*

TREATMENT–to be completed by Physician

Medication Prescribed

- ☐ **ABRAXANE® (paclitaxel protein-bound particles for injectable suspension) (albumin-bound)**
- ☐ **IDHIFA® (enasidenib)**
- ☐ **INREBIC® (fedratinib)**
- ☐ **ISTODAX® (romidepsin)**
- ☐ **ONUREG® (azacitidine)**
- ☐ **POMALYST® (pomalidomide)**
- ☐ **REBLOZYL® (luspatercept-aamt)**
- ☐ **REVLIMID® (lenalidomide)**
- ☐ **THALOMID® (thalidomide)**
- ☐ **VIDAZA®(azacitidine)**

Treatment Information

Patient Diagnosis - Primary ICD Code: Description:

Diagnostic Test Result (If Applicable):

Adjuvant Therapy? ☐ Yes ☐ No Will This Be? ☐ Monotherapy ☐ In Combination With:

Therapy Provided in: ☐ Inpatient ☐ Outpatient Hospital ☐ Outpatient Physician's Office ☐ Other:
(If an oral medication, select Other and specify)

Is Physician in Network With Patient's Insurance? ☐ Yes ☐ No

Previous Therapy Given*

Dates	Dose (in mg)	Therapy Given

Planned Therapy*

Dates	Dose (in mg)	Therapy Given

InitiateRx

Available for commercially insured ONUREG patients only. For eligible commercially insured new ONUREG patients, if a coverage determination is delayed for more than seven (7) business days, the patient will be provided ONUREG at no cost until coverage is received, a prior authorization is denied and appealed, or for one (1) year, whichever is earlier. Please see the complete Terms and Conditions on page 7 and select below if you would like your patient to be considered for this program.

☐ **InitiateRx**

Medication is dispensed directly to the patient's home address (shipments cannot be sent to PO Boxes). Medication will not be sent to the patient's healthcare provider. Prescribers must comply with the prescription requirements of their state.

*Include combination medications if relevant.

NO-US-2100752 09/21

Patient Name: _____ Date of Birth: _____

PHYSICIAN

PHYSICIAN INFORMATION–to be completed by Physician

Physician Name (first and last name):			
State License #:	Physician NPI #:		
Physician Tax ID #:	State Medicaid #:		
Facility Name:	Phone:	Fax:	
Facility Address:	City:	State:	Zip:
Primary Contact Name:	Phone:	Fax:	
Primary Contact Email Address:		Title:	

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, BMSPAF, and their respective agents and assignees, and I have obtained this patient's authorization for the disclosure, 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 patient receives medication from BMSPAF, 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 BMSPAF if my patient is enrolled in BMSPAF and I become aware that his/her insurance, treatment, or income status has changed; **(6)** I will not submit an insurance claim or other claim for payment to anyone else, including third-party payer (private or government) or the patient, and I forego any appeal of any denial of insurance coverage, for medication provided by either BMS or BMSPAF for this patient, nor will I count the free medication towards this patient's true out-of-pocket costs (TrOOP); and **(7)** Any medication provided by either BMS or BMSPAF 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 certify, if the patient enrolls in the BMS Access Support® Co-Pay Assistance Program for a physician-administered product, to the following:

- I have read and will comply with the Program Terms and Conditions on page 6
- 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
- If this office/site receives payment directly from the Program for this patient, the office/site will not accept payment from the patient for the amount received from the Program

I certify, if the patient is enrolled in the InitiateRx program for commercially insured patients, to the following:

- I have read and will comply with the Program Terms and Conditions on page 7
- 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

I understand that BMS and BMSPAF (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)

NO-US-2100752 09/21

PATIENT

PATIENT INFORMATION–to be completed by Patient

Personal Information

Patient Name (first and last name): ☐ Male ☐ Female Birth Date:

Address: City: State: Zip:

Home Phone: Mobile:

Insurance Information

Do You Have Insurance Through: ☐ Private/Employer-based Insurance ☐ VA or Military ☐ State Assistance Program for Medication ☐ Medicaid

CHECK ALL THAT APPLY

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

Financial, Drug, & Medication Information

(**Required** if Alternative Coverage or Support Research or Referral to BMSPAF is requested)

Financial Information

Your application may be subject to audit or request for additional documentation.

Number of people in your household (include yourself, your spouse, and your dependents):

Household income: Yearly: $ or Monthly: $

Social Security # (optional):

Drug Allergies: Do you have any drug allergies? ☐ Yes ☐ No If yes, please specify:

Medications: What medications are you currently taking?

Patient Name: _____ **Date of Birth:** _____

PATIENT

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. BMS also screens for patient assistance from the Bristol-Myers Squibb Patient Assistance Foundation, Inc. ("the Foundation"), an independent nonprofit that provides free medication to qualifying patients. To participate in the BMS Access Support program or to apply for the Foundation program, these programs will need to receive, use, and disclose your personal information. Please read this authorization for BMS and the Foundation 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 1-800-822-2496.

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
- Social Security number (which is voluntary)
- Professional and employment information
- Financial and income information
- Insurance informationHealth records and information, including medications
- Health records and information, including medications
- Biometric & Genetic information, including tests that identify the kind of illness that I have and/or medication indicated for my treatment

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, the Foundation, and their authorized agents and assignees (their "Administrators"). BMS and the Foundation and their 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 and/or Foundation programs
- Provide the BMS Access Support program services to me, including verifying my insurance benefits, researching insurance coverage options, and referring me and my caretakers to other plans, support, 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
- Provide me with free medication through BMS or the Foundation, if I qualify
- 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
86 Morris Avenue
Summit, NJ 07901

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.

I understand that if I receive free medication, I must reapply at least every year, sign an authorization for both BMS Access Support and the Foundation, 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, the Foundation, and their Administrators agree to use and disclose my information only for the purposes described in this authorization or as allowed or required by law. I understand that BMS or the Foundation does not sell or rent personal information collected about me from this Program.

I have a right to receive a copy of this authorization after I have signed it. 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® or Foundation programs. I understand that certain state laws may allow for the right to request access to, or deletion of, my information. I understand that these state rights are not absolute and only apply in certain circumstances. Therefore, I acknowledge that I may not receive a response to my request to the extent required or permitted under relevant laws. I agree that I may need to provide additional information in order to verify my identity, such as a government-issued ID, before my request to receive access to, or deletion of, my information will be honored. I will not be discriminated against for exercising my rights, but I understand that I

(continued on next page)

Patient Name: _____ Date of Birth: _____

PATIENT

PATIENT AUTHORIZATION AND AGREEMENT (cont.)

may not be able to receive Program services if I do not allow use of my information. To submit an access or deletion request, I may call 1-855-961-0474 or complete the online form at www.bms.com/dpo/us/request.

6. Patient certifications: I certify that the personal information that I provide to BMS and the Foundation is true and complete.

I agree that, at any time during my participation in either or both programs, BMS (and the Foundation, if applicable) 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 or free medication assistance from BMS, I agree to comply with BMS' program rules 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 understand that assistance may be temporary and that I may be required to apply every year. I will contact BMS Access Support at 1-800-861-0048 if my insurance or treatment changes in any way.

If I qualify for and receive free medication from the Foundation program, I agree to comply with the Foundation's program rules; 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. If I have Medicare Part D, I will also not count any free medication I receive towards my true out-of-pocket costs (TrOOP). I understand that the Foundation's help 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 Foundation at 1-800-736-0003 if my insurance, treatment, or financial situation changes in any way.

I understand that the BMS Access Support and the Foundation programs may be discontinued or the rules for participation may change at any time, without notice.

Medication Prescribed

- ☐ ABRAXANE® (paclitaxel protein-bound particles for injectable suspension) (albumin-bound)
- ☐ IDHIFA® (enasidenib)
- ☐ INREBIC® (fedratinib)
- ☐ ISTODAX® (romidepsin)
- ☐ ONUREG® (azacitidine)
- ☐ POMALYST® (pomalidomide)
- ☐ REBLOZYL® (luspatercept-aamt)
- ☐ REVLIMID® (lenalidomide)
- ☐ THALOMID® (thalidomide)
- ☐ VIDAZA® (azacitidine)

These are my written instructions and my permission for:

- BMSPAF and its Administrators to obtain a consumer report on me. My consumer report, and information derived from public and other sources, will be used to estimate my income as part of the process to decide if I am eligible to receive free medicine from BMSPAF. Upon request, BMSPAF will provide me the name and address of the consumer reporting agency that provides the consumer report. I may call BMSPAF at 1-800-736-0003 for this information.

PATIENT INITIALS: _____

Please initial here OR send in your income documentation.
Initialing here will speed up processing time for your application and will not impact your credit score.

I HAVE READ THIS AUTHORIZATION AND AGREE TO ITS TERMS:

Print Name of Patient or Personal Representative:

Description of Personal Representative's Authority: Zip:

Preferred Email Address: Phone:

Patient Date of Birth:

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. Power of Attorney documentation is required if someone other than the patient signs. You may fax the documents to 1-800-822-2496 or call 1-800-861-0048 for further assistance.

(continued on next page)

NO-US-2100752 09/21

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

[Program for ABRAXANE® (paclitaxel protein-bound particles for injectable suspension (albumin-bound), for intravenous use) & REBLOZYL® (luspatercept-aamt)]

The BMS Co-Pay Assistance Program is designed to assist eligible commercially insured patients who have been prescribed select BMS medications with out-of-pocket deductibles, co-pays, 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 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:

- This Program will cover the co-pay for each dose of a BMS medication, up to a maximum of $10,000 per BMS medication during a calendar year.
- 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 the date of the EOB.
- The Program may apply retroactively to out-of-pocket expenses that occurred within 180 days prior to the date of the enrollment. These benefits are subject to the 12-month Program maximum of $10,000 per medication.
- 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, supply charges or other treatment costs, or any costs associated with a hospital stay.
- All Program payments are for the benefit of the patient only.

Program Timing:

- The enrollment period is 1 calendar year.

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 benefits 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 Program 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.

NO-US-2100752 09/21

PHONE: 1-800-861-0048 | **FAX:** 1-800-822-2496

InitiateRx Terms & Conditions

[Program for ONUREG® (azacitidine) tablets]

Eligibility Requirements and Program Benefits

- This offer is available to new, commercially insured patients being treated with ONUREG for an FDA-approved indication who have enrolled in the Program.
- Patients who have prescription insurance coverage through Medicare, Medicaid, or any other federal or state healthcare program, or who are residents of Michigan, are not eligible.
- If a coverage determination is delayed for more than seven (7) business days, the patient will be provided ONUREG at no cost until coverage is received, a prior authorization is denied and appealed, or for one year, whichever is earlier.
- An appeal of any prior authorization denial must be made within 60 days or as per payer guidelines to remain in the Program.
- Patients continuing into the following year will be re-verified for eligibility in January. For patients whose insurance changes during the course of Program participation and otherwise remain eligible, a new prior authorization needs to be submitted.
- Program reserves the right to re-verify patient's insurance coverage at any point during the patient's participation in the Program.
- No claim for reimbursement for product dispensed under the Program may be made to any third-party payer.
- Participation in the Program is not conditioned on any past, present or future purchase, including refills.
- Valid only in the U.S.
- **The Program is not health insurance.**
- Other restrictions may apply.
- Bristol Myers Squibb reserves the right to modify or discontinue the Program at any time without notice.

NO-US-2100752 09/21