OnCall™ ORENCIA® (abatacept) Support Program

Enrollment Form

1-800-ORENCIA (1-800-673-6242) | 1-866-268-5385

ORENCIA® (abatacept)

PATIENT INFORMATION (REQUIRED to be completed by Patient)

Patient Contact 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: (please check all that apply)

☐ Private/Employer-based insurance ☐ VA or military ☐ State assistance program for medication ☐ Medicaid ☐ None

Medicare: ☐ Part A ☐ Part B ☐ Part D ☐ Medicare Advantage ☐ Other Prescription Coverage: _____

Medical Insurance	**Prescription Drug Insurance**
Primary Insurance Carrier:	**Primary Insurance Carrier:**
Policy ID Number:	Policy ID Number:
Phone: Group #:	Phone: Group #:
Policy Holder:	Policy Holder:
Secondary Insurance Carrier:	Rx BIN Number: Rx PCN Number:
Policy ID Number:	**Secondary Insurance Carrier:**
Phone: Group #:	Policy ID Number:
Policy Holder:	Phone: Group #:
	Policy Holder:
	Rx BIN Number: Rx PCN Number:

Financial Information (Required if Alternative Coverage or Support Research is requested)

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

Yearly household income: $ or Monthly household income: $

Social Security # (optional):

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

PHYSICIAN (REQUIRED to be completed by Physician)

Physician Information

Physician Name (first and last name):	State License #:	Physician NPI #:	State Medicaid #:
Facility Name:	Phone:	Fax:	Physician Tax ID #:
Facility Address:	City:	State:	Zip:
Primary Contact Name:	Title:	Primary Contact Email Address:	
Phone: Fax:	Preferred Method of Communication: ☐ Phone ☐ Fax ☐ Both	Note: If no option is selected, form will default to Both.	

Please see Important Safety Information on Page 4 and click here for U.S. Full Prescribing Information or visit ORENCIAhcp.com.

PHYSICIAN section *continued on page 2*

Assistance Requested (Please choose all assistance/programs desired)

IV Assistance:	SC Assistance:
☐ Benefits Review, Prior Authorization	☐ Benefits Review, Prior Authorization
☐ Appeals Assistance	☐ Appeals Assistance
☐ IV Co-Pay Assistance	☐ ORENCIA Commence Rx Program (if checked, please complete the corresponding section on **page 3**)
☐ Site of Care Services (choose if you or your patient need assistance locating an alternative site of care)	

☐ Alternative Coverage or Support Research (eg, independent charitable foundation referral)

BMS cannot guarantee acceptance by any program or foundation.

Treatment/Medication Prescribed

☐ ORENCIA Intravenous (IV)

ORENCIA Subcutaneous* (SC): ☐ New to Therapy ☐ New to Therapy with IV Loading Dose ☐ Transitioning from IV

***If prescribing SC method above, please indicate one or both administration forms desired:** ☐ Prefilled Syringe ☐ ClickJect™ Autoinjector

Clinical Information Patient Diagnosis: ICD 10 Code of FDA approved use: _____

Site of Care Services (Required if Site of Care services are requested) – IV Patients only

Please indicate alternate site preference, if any:

☐ Non-prescribing MD's Office ☐ Hospital Outpatient Facility ☐ Home Infusion/Infusion Provider Company ☐ Other: _____

If alternate site of service is known, please fill out below:

Physician or Provider Name (first and last name):

Practice/Facility Name:	Insurance Provider #:		Tax ID #:
Facility Address:	City:	State:	Zip:
Primary Contact Name:	Phone:	Fax:	

Physician Certification

I certify to the following: (1) to the best of my knowledge, the information that I provide to BMS 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 for the disclosure, if required by HIPAA or other applicable privacy laws; and (3) treatment with the above medication is medically necessary and for an FDA-approved use.

I certify, if the patient enrolls in ORENCIA IV Co-Pay Assistance, to the following:

- I have read and will comply with the Program Terms and Conditions on page 3
- 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 ORENCIA IV administered to the patient
- The bill or claim that this office/site will submit to the insurer or patient for payment for ORENCIA IV 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 understand that BMS (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) is relying on these certifications.

SIGNATURE

Prescriber's signature _____ **Date**

Physician or Licensed Prescriber signature (required—no stamps)

Please see Important Safety Information on Page 4 and click here for U.S. Full Prescribing Information or visit ORENCIAhcp.com.

ORENCIA Commence Rx (Optional for commercially insured patients) – SC Patients only

For eligible commercially insured new subcutaneous (SC) ORENCIA patients, if a coverage determination is delayed for more than ten (10) business days, the patient will be provided subcutaneous (SC) ORENCIA at no cost until coverage is received, a prior authorization is denied and not appealed, or for one year, whichever is earlier. Please see the complete Terms and Conditions below and complete this section if you would like your patient to be considered for this program.

Dispensing Instructions for ORENCIA SC:

- ☐ 125-mg ClickJect™ Autoinjector SC once-weekly, Quantity #4, 12 refills
- ☐ 50-mg pre-filled syringe SC once-weekly, Quantity #4, 12 refills
- ☐ 87.5-mg pre-filled syringe SC once-weekly, Quantity #4, 12 refills
- ☐ 125-mg pre-filled syringe SC once-weekly, Quantity #4, 12 refills

Delivery Instructions:

Patient Name: _____
Patient Birth Date: _____
Patient Phone Number: _____
Patient Street Address: _____
City, State, Zip: _____

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. For prescribers in a state with official prescription form requirements, such as New York, please submit prescriptions on an official state prescription form, in addition to this form.

SIGNATURE

Prescriber's signature _____ **Date** _____

Physician or Licensed Prescriber Signature (required—no stamps)

ORENCIA Commence Rx Terms & Conditions

1. This offer is available to eligible commercially insured new subcutaneous ORENCIA patients only.
2. Patients who have prescription insurance coverage through Medicare, Medicaid, or any other federal or state healthcare program, or who are residents of Massachusetts and Michigan, are not eligible. Offer is available for no more than 6 months to residents of Minnesota and Rhode Island.
3. Available only for patients being treated with subcutaneous ORENCIA for an FDA-approved indication.
4. If a coverage determination is delayed for more than ten (10) business days, the patient will be provided subcutaneous ORENCIA at no cost until coverage is received, a prior authorization is denied and not appealed, or for one year, whichever is earlier.
5. Patients continuing into the following year will be re-verified for eligibility in January. For patients whose insurance coverage changes during the course of program participation and otherwise remain eligible, a new prior authorization needs to be submitted.
6. Program reserves the right to re-verify patient's insurance coverage at any point during the patient's participation in the program.
7. No claim for reimbursement for product dispensed pursuant to this offer may be made to any third-party payer.
8. This offer is not conditioned on any past, present, or future purchase, including refills.
9. Valid only in the U.S.
10. This offer is not health insurance.
11. Other restrictions may apply.
12. Bristol Myers Squibb reserves the right to rescind, revoke, or amend this offer at any time without notice.

ORENCIA IV Co-Pay Assistance Terms & Conditions

ORENCIA IV Co-Pay Assistance is designed to assist eligible commercially insured patients who have been prescribed ORENCIA IV with out-of-pocket deductibles, co-pay, 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 Options Program [SHOP] Marketplace), you are currently eligible.
- You live in the United States or Puerto Rico.

Program Benefits:

- Patient must pay the first $5 of the co-pay for each dose of a BMS medication covered by this Program. This Program will cover the remainder of the co-pay, up to a maximum of $15,000 during a calendar year. Patients are responsible for any costs that exceed the Program's $15,000 maximum.
- 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 receiving each dose.
- The Program may apply retroactively to out-of-pocket expenses that occurred within 120 days prior to the date of the enrollment. These benefits are subject to the $5 patient co-pay requirement and the 12-month Program maximum of $15,000.
- 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.
- 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 benefit 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.

Please see Important Safety Information on Page 4 and click here for U.S. Full Prescribing Information or visit ORENCIAhcp.com.

IMPORTANT SAFETY INFORMATION FOR ORENCIA® (abatacept)

Indications and Usage

Adult Rheumatoid Arthritis: ORENCIA® (abatacept) is indicated for the treatment of adult patients with moderately to severely active rheumatoid arthritis (RA).

Polyarticular Juvenile Idiopathic Arthritis: ORENCIA is indicated for the treatment of patients 2 years of age and older with moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA).

Adult Psoriatic Arthritis: ORENCIA is indicated for the treatment of adult patients with active psoriatic arthritis (PsA).

Limitations of Use: The concomitant use of ORENCIA with other potent immunosuppressants [e.g., biologic disease-modifying antirheumatic drugs (bDMARDS), Janus kinase (JAK) inhibitors] is not recommended.

Important Safety Information for ORENCIA® (abatacept)

Concomitant Use with TNF Antagonists, Other Biologic RA/PsA Therapy, or JAK Inhibitors: Concurrent therapy with ORENCIA and a TNF antagonist is not recommended. In controlled clinical trials, adult RA patients receiving concomitant intravenous ORENCIA and TNF antagonist therapy experienced more infections (63% vs 43%) and serious infections (4.4% vs 0.8%) compared to patients treated with only TNF antagonists, without an important enhancement of efficacy. Additionally, concomitant use of ORENCIA with other biologic RA/PsA therapy or JAK inhibitors is not recommended.

Hypersensitivity: There were 2 cases (<0.1%; n=2688) of anaphylaxis reactions in clinical trials with adult RA patients treated with intravenous ORENCIA. Other reactions potentially associated with drug hypersensitivity, such as hypotension, urticaria, and dyspnea, each occurred in <0.9% of patients. There was one case of a hypersensitivity reaction with ORENCIA in pJIA clinical trials (0.5%; n=190). In postmarketing experience, fatal anaphylaxis following the first infusion of ORENCIA and life-threatening cases of angioedema have been reported. Angioedema has occurred as early as after the first dose of ORENCIA, but also has occurred with subsequent doses. Angioedema reactions have occurred within hours of administration and in some instances had a delayed onset (i.e., days). Appropriate medical support measures for treating hypersensitivity reactions should be available for immediate use. If an anaphylactic or other serious allergic reaction occurs, administration of intravenous or subcutaneous ORENCIA should be stopped immediately and permanently discontinued, with appropriate therapy instituted.

Infections: Serious infections, including sepsis and pneumonia, were reported in 3% and 1.9% of RA patients treated with intravenous ORENCIA and placebo, respectively. Some of these infections have been fatal. Many of the serious infections have occurred in patients on concomitant immunosuppressive therapy which, in addition to their underlying disease, could further predispose them to infection. Caution should be exercised in patients with a history of infection or underlying conditions which may predispose them to infections. Treatment with ORENCIA should be discontinued if a patient develops a serious infection. Patients should be screened for tuberculosis and viral hepatitis in accordance with published guidelines, and if positive, treated according to standard medical practice prior to therapy with ORENCIA.

Immunizations: Prior to initiating ORENCIA in pediatric and adult patients, update vaccinations in accordance with current vaccination guidelines. Live vaccines should not be given concurrently with ORENCIA or within 3 months after discontinuation. ORENCIA may blunt the effectiveness of some immunizations.

Use in Patients with Chronic Obstructive Pulmonary Disease (COPD): In Study V, adult COPD patients treated with ORENCIA for RA developed adverse events more frequently than those treated with placebo, including COPD exacerbations, cough, rhonchi, and dyspnea. In the study, 97% of COPD patients treated with ORENCIA developed adverse events versus 88% treated with placebo. Respiratory disorders occurred more frequently in patients treated with ORENCIA compared to those on placebo (43% vs 24%, respectively), including COPD exacerbation, cough, rhonchi, and dyspnea. A greater percentage of patients treated with ORENCIA developed a serious adverse event compared to those on placebo (27% vs 6%), including COPD exacerbation [3 of 37 patients (8%)] and pneumonia [1 of 37 patients (3%)]. Use of ORENCIA in patients with COPD should be undertaken with caution, and such patients monitored for worsening of their respiratory status.

Immunosuppression: In clinical trials in adult RA patients, a higher rate of infections was seen in ORENCIA-treated patients compared to placebo-treated patients. The impact of treatment with ORENCIA on the development and course of malignancies is not fully understood. There have been reports of malignancies, including skin cancer in patients receiving ORENCIA. Periodic skin examinations are recommended for all ORENCIA-treated patients, particularly those with risk factors for skin cancer.

Blood Glucose Testing: ORENCIA for intravenous administration contains maltose, which may result in falsely elevated blood glucose readings on the day of infusion when using blood glucose monitors with test strips utilizing glucose dehydrogenase pyrroloquinoline quinone (GDH-PQQ). Consider using monitors and advising patients to use monitors that do not react with maltose, such as those based on glucose dehydrogenase nicotine adenine dinucleotide (GDH-NAD), glucose oxidase or glucose hexokinase test methods. ORENCIA for subcutaneous (SC) administration does not contain maltose; therefore, patients do not need to alter their glucose monitoring.

Pregnancy: There are no adequate and well-controlled studies of ORENCIA use in pregnant women and the data with ORENCIA use in pregnant women are insufficient to inform on drug-associated risk. A pregnancy registry has been established to monitor pregnancy outcomes in women exposed to ORENCIA during pregnancy. Healthcare professionals are encouraged to register patients by calling 1-877-311-8972.

Lactation: There is no information regarding the presence of abatacept in human milk, the effects on the breastfed infant, or the effects on milk production. However, abatacept was present in the milk of lactating rats dosed with abatacept.

Most Serious Adverse Reactions: Serious infections (3% ORENCIA vs 1.9% placebo) and malignancies (1.3% ORENCIA vs 1.1% placebo).

Malignancies: The overall frequency of malignancies was similar between adult RA patients treated with ORENCIA or placebo. However, more cases of lung cancer were observed in patients treated with ORENCIA (0.2%) than those on placebo (0%). A higher rate of lymphoma was seen compared to the general population; however, patients with RA, particularly those with highly active disease, are at a higher risk for the development of lymphoma. The potential role of ORENCIA in the development of malignancies in humans is unknown.

Most Frequent Adverse Events (≥10%): Headache, upper respiratory tract infection, nasopharyngitis, and nausea were the most commonly reported adverse events in the adult RA clinical studies. Other events reported in ≥5% of pJIA patients were diarrhea, cough, pyrexia, and abdominal pain. In general, the adverse events in pediatric pJIA and adult PsA patients were similar in frequency and type to those seen in adult RA patients.

Note concerning ORENCIA administration options: ORENCIA may be administered as an intravenous infusion only for patients 6 years of age and older. PJIA patients may self-inject with ORENCIA or the patient's caregiver may administer ORENCIA if both the healthcare practitioner and the parent/legal guardian determines it is appropriate. The ability of pediatric patients to self-inject with the autoinjector has not been tested.

Please click here for U.S. Full Prescribing Information or visit ORENCIAhcp.com.

PATIENT AUTHORIZATION AND AGREEMENT

ORENCIA® On Call Access Assistance

ORENCIA® On Call is a support program for patients by Bristol-Myers Squibb Company (BMS). Through this authorization and agreement I choose to participate in On Call Access Assistance, which helps patients understand their insurance coverage and financial support options for ORENCIA® (abatacept) and provides co-pay assistance and/or free medication to those who qualify. I have the option to also participate in On Call Patient Education and Resources by separately enrolling below. To participate in On Call Access Assistance (the "Program"), BMS will need to receive, use, and disclose your personal information. Please read this authorization carefully, and contact ORENCIA On Call at 1-800-ORENCIA if you have any questions.

1. What information will be used and disclosed?

My personal information will be disclosed, including:

- Information on the Program enrollment form
- My contact information
- Date of birth and Social Security number (SSN is voluntary)
- Financial and Income information
- Insurance benefit information
- Health records and information, including diagnoses, medications, and lab tests
- 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, pharmacies, health plans or insurers who provide services to me, as well as other people that I say can help me apply (my "caretakers"), to disclose my personal information to BMS, the third parties it works with, and its authorized agents, subsidiaries, and assignees (collectively "BMS"). BMS 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 BMS and my caretakers to:

- Process my application for the Program and provide the Program services to me, including verifying my insurance benefits, assistance with prior authorizations from my insurance, researching alternative 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 and/or free medication to me, if I qualify
- Contact me and my caretakers about other programs and 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 and other internal business purposes including analytics

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 the Program, and if I enroll in On Call Patient Education and Resources described below, by writing to:

ORENCIA On Call
P.O. Box 221509
Charlotte, NC 28222-1509

If I cancel this authorization for one or both of these Programs, I will no longer be able to participate in the Program(s). The Program(s) 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 may use and disclose my information for the purposes described in this authorization or as allowed or required by law. I understand that BMS 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 Program services. 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

(continued on next page)

PATIENT AUTHORIZATION AND AGREEMENT

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 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 is true and complete. I agree that, at any time during my participation, 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 or free medication from BMS, I agree to comply with the Program rules on my enrollment form 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 the Program at 1-800-ORENCIA (1-800-673-6242) if my insurance or treatment changes in any way. If I have Medicare Part D, I will also not count on any free medication I receive toward my true out-of-pocket (TrOOP) costs. I understand that the Program may be discontinued or the rules for participation may change at any time, without notice.

I Agree To Enroll In On Call Access Assistance

Patient Name:

Patient Signature: Date:

If signed by a personal representative, please print name of personal representative:

If signed by personal representative, please explain authority to act on behalf of the patient:

Patient Date of Birth: ZIP:

Preferred E-mail Address:

ORENCIA® On Call Patient Education & Resources

ORENCIA® On Call Patient Education and Resources is designed to provide patients with information and services related to my disease, ORENCIA refill reminders, surveys, and other information and alerts. By signing below, I agree to enroll in On Call Patient Education and Resources. BMS may contact me via mail, text/SMS, telephone, in electronic format or otherwise. BMS may also contact me about additional information, market research, clinical trials, and other offers that BMS believes may be of interest to me. My personal information may be used by and shared with BMS, the third parties it works with, and its authorized agents, subsidiaries, and assignees (collectively "BMS") to provide the services as well as to for other purposes including improving or developing other communications and services, internal business purposes, including analytics. Information collected as part of this support program will be governed by the BMS privacy policy available on bms.com, which may change from time to time and I should check the website for the most recent version. I can stop future marketing communications and use of my information by calling 1-800-ORENCIA (1-800-673-6242).

I Agree To Enroll in On Call Patient Education and Resources

Patient Name:

Patient Signature: 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.

Bristol Myers Squibb™

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