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 Name: (first and last name)		Gender:	Birth Date: / /
Address:	City:	State:	Zip:
Phone Number:	**Clinical Information** Patient Diagnosis: ICD 10 Code of FDA approved use:		

Insurance Information

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:

PHYSICIAN INFORMATION (REQUIRED to be completed by Physician)

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

Preferred Method of Communication: ☐ Phone ☐ Fax ☐ Both   Note: If no option is selected, form will default to Both.

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: (1) I have read and will comply with the Program Terms and Conditions on page 2; (2) 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; (3) 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; (4) 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; (5) 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; (6) 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.

ORENCIA Commence Rx® Bridge Program (Optional for commercially insured SC patients only)

For eligible commercially insured 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 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

Commence Rx Pharmacy: 1-877-654-7812
Patients should save the Commence Rx specialty pharmacy number in their phone. The pharmacy may contact them to schedule shipments of ORENCIA SC.

SCAN TO ADD TO CONTACTS

Medication is dispensed directly to the patient's home address (shipments cannot be sent to P.O. 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)

Please complete Treatment/Medication Prescribed Section on Page 2

Please see Full Prescribing Information and Medication Guide at www.orenciahcp.com.

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ORENCIA® (abatacept)

Treatment/Medication Prescribed

☐ ORENCIA Intravenous (IV)

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

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

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:	

ORENCIA Commence Rx Terms & Conditions

1. This offer is available to eligible commercially insured subcutaneous ORENCIA patients only.
2. Patients who have prescription insurance coverage through Medicare, Medicaid, or another federal or state healthcare program, or who are residents of Puerto Rico, are not eligible.
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 or for up to one year, whichever is earlier. To remain in the program, appeal of any prior authorization denial must be made within 30 days. If a prior authorization is denied and not appealed, patients will be ineligible to remain in the program.
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. Not valid in Puerto Rico.
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.

- Patients must have commercial insurance that pays for ORENCIA but does not cover the full cost. Co-pay assistance is not available if patient out-of-pocket expenses are $5 or less.
- Patients who have insurance coverage through a state or federal healthcare program, including Medicare, Medicaid, Medigap, CHAMPVA, Tricare, Veterans Affairs (VA), or Department of Defense (DoD), are not eligible. Patients who move from commercial to federal health insurance will no longer be eligible.
- Cash-paying patients are not eligible for co-pay assistance.
- Patients must be treated with ORENCIA for an FDA-approved indication.
- Patients or their guardian must be 18 years of age or older.
- Eligible patients with an activated co-pay card and a valid prescription may pay as little as $5 per 30-day supply; monthly, annual, and/or per-claim maximum program benefits may apply and vary from patient to patient, depending on the terms of a patient's prescription drug plan and to ensure that the funds are used for the benefit of the patient, based on factors determined solely by Bristol Myers Squibb.
- Some prescription drug plans have established programs referred to as 'co-pay maximizer' programs. A co-pay maximizer program is one in which the amount of the patient's out-of-pocket costs is adjusted to reflect the availability of support offered by a co-pay support program. Patients enrolled in co-pay maximizer programs may receive program benefits that vary over time to ensure the program funds are used for the benefit of the patient.
- For ORENCIA subcutaneous self-injection, the Co-pay Assistance Card must be presented at the pharmacy, along with a valid prescription for ORENCIA, at the time of purchase.
- The Card must be activated before use and includes 13 uses per calendar year. Patients will be evaluated for ongoing eligibility to continue enrollment in the program. In the event patients experience a change in insurance coverage or Bristol Myers Squibb makes changes to the copay assistance program, patients may be required to re-enroll into the program and provide updated insurance information to determine eligibility.
- For ORENCIA IV infusion, in order to receive 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, show that ORENCIA IV was the medication given, and be submitted within 180 days of receiving each dose. The enrollment period is 1 calendar year. The Program may apply to out-of-pocket expenses that occurred within 180 days prior to the date of enrollment. Copay assistance payment will expire and will no longer be available if not used within 180 days of payment issuance.
- Program benefits are limited to the co-pay costs for ORENCIA that the patient receives as an outpatient. The Program will not cover the cost of any dosing procedure, any other healthcare provider service, supply charges, or other treatment costs.
- Program payments are for the benefit of the patient only.
- Patients, guardians, pharmacists, and healthcare providers may not seek reimbursement from health insurance or any third party for any part of the benefit received by the patient through this 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 if required by the patient's insurance provider.
- Offer valid only in the United States and Puerto Rico; void where prohibited by law, taxed, or restricted.
- Program benefits are nontransferable. This offer may not be combined with any other rebate/coupon, free trial, or similar offer.
- Co-pay cards are limited to 1 per patient and may not be sold, purchased, traded, or counterfeited.
- No membership fees.
- Program offer is not conditioned on any past, present, or future purchase, including additional doses or refills.
- **The Program is not insurance.**
- Bristol Myers Squibb reserves the right to rescind, revoke, or amend this offer at any time without notice. Other restrictions may apply.

Please see Full Prescribing Information and Medication Guide at www.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 (continued)

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: Power of Attorney documentation is required if someone other than the patient signs. "You may fax the documents to 1-866-268-5385 or call 1-800-673-6242 for further assistance."	
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 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 the Terms and Conditions (https://www.orencia.com/text-message-terms-conditions) of this Mobile Program and Privacy Policy (https://www.bms.com/privacy-policy.html). I consent to receive autodialed text messages on behalf of Bristol Myers Squibb. I understand that I will receive no more than 3 messages a month during the course of this program. Consent is not a condition of purchase or use of any Bristol Myers Squibb product. The Program is valid with most major U.S. carriers. I understand that message and data rates may apply. I understand that I can opt-out at any time by texting STOP to [42247]. I agree to receive one final text confirming my opt-out request.

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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