## Section I: Patient Information
(TO BE COMPLETED BY PATIENT. ALL BOXES ARE REQUIRED EXCEPT WHERE NOTED.)

| | | |
|---|---|---|
| Patient Name: | Social Security Number *(optional)*: | |
| Date of Birth: | Gender: ☐ Female ☐ Male | |
| Patient Address *(no PO Boxes)*: | | |
| City: | State: | Zip: |
| Home Phone: | Cell Phone *(optional)*: | Email Address *(optional)*: |
| Alternate Contact Name *(optional)*: | Relationship *(Required if Alternative Contact is provided)* ☐ Family Member ☐ Friend ☐ Other *If Other, please specify relationship:* _____ | Alternate Contact Phone *(Required if Alternative Contact is provided)*: |

Please note that an Alternate Contact may not be an individual associated with or a representative of your insurance company or their business partners.

**PATIENT INSURANCE INFORMATION** – Do you have insurance through any of these providers? *(Check all that apply)*

| | | |
|---|---|---|
| ☐ Medicaid | ☐ Medicare: ☐ Part A ☐ Part B ☐ Part D ☐ Medicare Part D LIS/Extra Help ☐ Part C/Medicare Advantage | |
| ☐ VA or Military | ☐ Private Insurance | ☐ None |
| ☐ State Assistance Program for Medication | ☐ Other: | |

For patients seeking assistance in 2024: If you are age 65 and over, have income less than 150% of the federal poverty level and have been prescribed ELIQUIS®, ORENCIA® Subcutaneous or SOTYKTU™, you will be asked to provide proof of denial for the Medicare Part D LIS/Extra Help. For more information, please visit BMSPAF.org or call 800-736-0003.

| INSURANCE NAME | PHONE # | ID/POLICY # |
|---|---|---|
| Primary: | | |
| Secondary: | | |
| Prescription Coverage: *(Attach a copy of both sides of your prescription insurance card)* | | ID/Policy #: RxBIN: RxPCN: |

Number of people living in your home: *(Include yourself, your spouse, and any dependents **currently** living with you)*

| | | |
|---|---|---|
| TOTAL YEARLY HOUSEHOLD INCOME: $ | **OR** | TOTAL MONTHLY HOUSEHOLD INCOME:$ |

**Proof of income may be required: Please provide your most recent federal tax return. If your federal tax return is not available, please provide as many of the following as available: W2, 1099, pension statement, Social Security statement, at least 2 consecutive pay stubs.**

**Medicare Part D recipients: You may be eligible for assistance if you have spent at least 3% of your annual household income on out-of-pocket (OOP) prescription expenses during the same year for which you need assistance from BMSPAF. For example, if you are applying for assistance for 2024, please attach 2024 OOP prescription expenses to this application. Your pharmacy can provide you with your year-to-date OOP expenses. Applications may not be fully processed without proof of these expenses.**

**Please continue to the next page to read, sign, and date the Patient Agreement & Consent.**

## Patient Agreement & Consent

### I promise that:

All of the information I provided in my application, and other documents or information that I may provide, are complete and true. • If I am approved (enrolled), I agree that I will not be reimbursed for the free medicine from anyone else, including a prescription insurance program or any other charity. If I have Medicare Part D, I will not count any free medicine toward my true out-of-pocket costs (TrOOP). • If my insurance coverage or income changes in any way, I will immediately notify BMSPAF.

### To the best of my knowledge:

My insurance plan did not require me to apply to BMSPAF and/or change or hide my insurance coverage to make me appear to be underinsured and eligible for BMSPAF. • The Alternate Contact listed on my application (if any) is not associated with or a representative of my insurance company or the insurance company's business partners.

### I give my permission to:

My insurance providers, healthcare providers, and others helping me apply to this program, to share information about me with BMSPAF and the companies that BMSPAF uses to administer the program (Administrators). • My information that will be shared includes my personal information in my application, as well as my health information and records, insurance information, and financial and income information. • BMSPAF and its Administrators to use my information, and share it with my healthcare providers, my insurance company, and other organizations or companies that might be able to help me, so that BMSPAF and its Administrators may: decide if I am eligible for the program, help me get the free medicine during my enrollment (if I am eligible), and find out if I may be eligible for, or already enrolled in, another program (including a prescription insurance plan or another charitable program).

### I understand that:

BMSPAF and its Administrators may contact me by phone or other methods to ask for additional information at any time, even if I am enrolled, so that they can decide if the information on my application is complete and true. • BMSPAF and its Administrators may delay, deny, or end my enrollment if my application is missing information or I do not respond to requests for documents or information. • If I am enrolled, BMSPAF will only give me free medicine for a short time, and I will have to reapply before my enrollment ends if I still need help with free medicine. •I may not be eligible for free medicine if I have insurance coverage that will pay for my medicine (other than eligible patients covered under Medicare Part D). • I understand that once my information has been disclosed, privacy laws may no longer restrict its use or disclosure. BMSPAF and its Administrators will share my information as described in this consent form or as required or allowed by law. • I may refuse to sign this consent form and 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 this program. • This consent will be effective for 18 months unless it expires earlier by law, or I cancel it in writing. I may cancel this consent at any time by writing to BMSPAF at the address in this application. If I cancel this consent, I will no longer be eligible for the program and my enrollment will end. • I have a right to receive a copy of this form after I have signed it. • BMSPAF may change or stop the program at any time without notice.

**Print Patient Name:** _____

**Patient Signature:** _____ **Date:** _____

You must sign and date to apply.

### 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 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.