BRISTOL-MYERS SQUIBB
ONCOLOGY/VIROLOGY

Bristol-Myers Squibb Company

BRISTOL-MYERS SQUIBB - AMERICARES ONCOLOGY/VIROLOGY ACCESS PROGRAM APPLICATION INSTRUCTIONS

(FOR CANCER AND AIDS DRUGS)

The Bristol-Myers Squibb – AmeriCares Oncology/Virology Access Program is designed to provide assistance to patients with a financial hardship who are not eligible for outpatient prescription drug assistance through Medicaid, ADAP, or any other public or private program.

Attached is an application form for the program. This form should be completed to request assistance in obtaining cancer and AIDS drugs. Please call the toll-free number listed below if you are not sure if this is the correct application for the drug that you need.

To avoid delays in processing your request for product, it is important to complete the entire application, leaving no areas blank.

The first section is to be completed by the prescribing physician. Product may only be shipped to the prescribing physician. Please include **ALL** product information [BMSOV product(s) requested, dose/strength, frequency, total # of cycles, and therapy dates (given and/or planned)]. **The physician must sign the application.** (Stamped signatures or signatures by persons other than the prescribing physician are not acceptable.)

The second section is to be completed by the patient or patient advocate. Please include **ALL** financial information (total monthly net family income, total liquid assets, and total monthly out-of-pocket family medical expenses). If any of these figures is zero, please enter "0" in the space provided rather than leaving it blank. Please list all health insurance policies (including Medicare), along with telephone number(s) and policy or ID number(s). **The patient must sign the application**.

Upon completion of this application, the **physician's office** should call our Reimbursement Counselors toll-free at:

Phone Number: (800) 272-4878
Monday through Friday
8:00am-5:00pm CST

Our counselors will assign a unique case number to this application and will provide instructions for submitting the application by FAX or mail. If you have any questions about completing this application, please call the toll-free phone number listed above and one of our counselors will assist you.

BRISTOL-MYERS SQUIBB - AMERICARES
ONCOLOGY/VIROLOGY ACCESS PROGRAM

Bristol-Myers Squibb Oncology/Virology offers its products to eligible patients free of charge through AmeriCares. Assistance will be considered on the basis of greatest need. While Bristol-Myers Squibb will make every effort to grant aid to as many patients as possible, this program is limited by available resources and is subject to change or cancellation.

BMSOV USE ONLY:	( ) Oncology	( ) Virology	I	R	Case #	IC Date

PLEASE PRINT OR TYPE

THIS SECTION TO BE COMPLETED BY PRESCRIBING PHYSICIAN

PHYSICIAN NAME	MEDICAID PROVIDER# DEA#
FACILITY NAME	FACILITY TAX ID#
MAILING ADDRESS	SHIPPING ADDRESS
CITY/STATE/ZIP	CITY/STATE/ZIP
PHONE # ( ) -	CONTACT NAME PHONE #

BMSOV PRODUCTS REQUESTED	DOSE	FREQUENCY	TOTAL CYCLES	OUTPT. THERAPY DATES (GIVEN/PLANNED)

I certify that, to the best of my knowledge, the patient referenced below is unable to afford the medication and does not qualify for any assistance with prescription drug costs from private or public sources. I acknowledge my responsibility for receiving the product, storing it separately, and providing it for the **outpatient treatment** of this patient only. I represent that the patient information I have provided is consistent with applicable privacy laws and regulations, and I understand that AmeriCares and/or its agents are relying on this representation.

PHYSICIAN'S ORIGINAL SIGNATURE_____ **DATE**_____

THIS SECTION TO BE COMPLETED BY PATIENT OR PATIENT ADVOCATE

PATIENT'S NAME or INITIALS_____ First MI Last STREET _____ CITY_____ STATE_____ ZIP CODE_____	US RESIDENT : ( ) YES ( ) NO SS# : BIRTH DATE : # DEPENDENT ON FAMILY INCOME : _____

Total Monthly Net Family Income	**Total Family Liquid Assets:**	**Average Monthly Out-of-Pocket Family Medical Expenses**
$_____ To include salary, pension, SS, disability; earnings from dividends, rental property; etc.	$_____ To include savings, checking, money market accounts; CDs, IRAs; est. market value of stocks, bonds, mutual funds; etc.	$_____ To include prescriptions, doctor visits, labs, hospital, etc.

PLEASE RESPOND TO EACH **PATIENT INSURANCE/ASSISTANCE INFORMATION**

DOES THE PATIENT QUALIFY FOR:	INSURANCE COMPANY NAME	TELEPHONE NUMBER	ID/POLICY NUMBER
Medicare **( ) Yes ( ) No**			
Private Insurance **( ) Yes ( ) No**			
Veterans **( ) Yes ( ) No**			
Other State Aid **( ) Yes ( ) No**			

MEDICAID (check one): **( ) NOT ELIGIBLE/DENIED** (Reason: _____) or **( ) PENDING APPROVAL**

If Applicable: Medicaid ID#_____ Telephone # Medicaid Office: _____

AIDS DRUG ASSISTANCE PROGRAM (ADAP) (check one): **( ) NOT ELIGIBLE/DENIED** (Reason: _____) or **( ) PENDING APPROVAL/ON WAIT LIST**

If Applicable: ADAP ID#_____ Telephone # ADAP Office: _____

I attest to the above information being correct and complete to the best of my knowledge. By my signature, I authorize the release of the above information to AmeriCares (AmC)/its agents, and I authorize AmC/its agents to use the above information to contact my insurer, other potential funding sources, social workers, or patient advocacy organizations on my behalf to determine my eligibility for alternative prescription drug assistance. I also authorize AmC/its agents to contact my insurer, health care provider, or dispensing agent to request information, and I authorize the aforementioned entities to disclose information to AmC/its agents, relative to my medical condition, treatment or drug therapy as requested by AmC/its agents. Disclosure of this information may include, but is not limited to, the electronic transmission of information. AmC/its agents agree to request only that information needed to process this application, to renew it, and to provide continued assistance during my participation in the program. AmC/its agents agree not to disclose any information obtained from these sources to any third party except as authorized by me or as required by applicable law. This authorization shall continue in effect as long as I am a participant in the program.

PATIENT'S SIGNATURE or INITIALS_____ **DATE**_____