ZEPOSIA (ozanimod) 0.92 mg capsules 360 SUPPORT™ covermymeds®

GASTROENTEROLOGY START FORM

TO HEALTHCARE PROVIDERS: Fax this page and a copy of insurance and pharmacy benefit cards (both sides of each) to **1-833-727-7701** or enroll online at www.covermymeds.com

PATIENTS

Please fill out this section, then read and sign the Patient Authorization and Agreement on pages 2 and 3. This is required in order to submit the form. If any information or your signature is missing, it may cause delays in filling your prescriptions and signing you up for the ZEPOSIA 360 Support™ Program.

1: PATIENT INFORMATION

First name ____ MI ____ Last name ____ DOB ____

Address ____ City ____ State ____ ZIP ____

E-mail *(required for co-pay enrollment)* ____ Preferred language: ☐ English ☐ Spanish ☐ Other ____

Phone ____ ☐ OK to leave voicemail ☐ Male ☐ Female ☐ Other

2: PRESCRIPTION INSURANCE COVERAGE

☐ Check here if you do not have prescription drug insurance

Prescription insurance carrier ____ Rx Member ID ____ Insurance phone ____

Rx PCN (if applicable) ____ Rx Group ID ____ Rx BIN (if applicable) ____

☐ See attached copy of my insurance card(s), front and back, for the information requested above.

For Healthcare Professionals

Please fill out the following sections and **sign this page**. **Fax COMPLETED pages 1-3.**

3: PRESCRIBER INFORMATION

First name ____ Last name ____ Office/Clinic/Institution name ____

Address ____ City ____ State ____ ZIP ____

Phone ____ Fax ____ NPI # ____ State medical license # ____

E-mail ____ Office contact name ____ Office phone ____

Office e-mail ____ Best time to contact: ☐ Morning ☐ Afternoon

4: ASSESSMENTS

Are you requesting screening assistance? ☐ **NO** assistance requested—patient is cleared for therapy

YES, assistance requested to conduct the following screenings at patient's home (check all that apply)*:

Blood tests: ☐ CBC ☐ LFTs **Screenings:** ☐ ECG

Note: Screening only for select patients: ☐ VZV antibody serology ☐ Macular edema screening

*Please see additional eligibility requirements and Terms and Conditions on page 4.

5: CLINICAL INFORMATION

Primary Diagnosis:

☐ ICD 10 K51.90 (Ulcerative Colitis, unspecified, without complications)
☐ ICD 10 K51.80 (Other Ulcerative Colitis, without complications)
☐ ICD 10 K51.00 (Ulcerative [chronic] Pancolitis, without complications)
☐ Other ____

Most recent UC therapy: ____ (MM/YY) ____ to ____

Concurrent medications: ____

Drug and non-drug allergies: ____

☐ No known drug allergies (NKDA)

6: PRESCRIPTION(S)

Patient name ____ DOB ____

Initiation Rx*

(optional free trial offer available for eligible patients)

Has patient already initiated ZEPOSIA® (ozanimod)? ☐ No ☐ Yes
(if yes, add start date (MM/YY): ____/____ and skip to "Maintenance Rx" section.)

☐ ZEPOSIA® (ozanimod) Starter Kit, one capsule by mouth once daily per package titration instructions, 1 kit, 0 refills
OR
☐ 7-day Titration Pack only, 0 refills (restarting patients)

Send to:
☐ Prescriber address ☐ Patient address

Address ____
City ____ State ____ ZIP ____

*Please see additional eligibility requirements and Terms and Conditions on page 4.

Maintenance Rx

ZEPOSIA® (ozanimod) 0.92 mg capsules once daily:
☐ 30-day supply followed by 11 refills or ____ refills
OR
☐ 90-day supply followed by 3 refills or ____ refills

Specialty pharmacy name: ____

☐ Follow up with my specialty pharmacy for patient prior authorization

Additional notes: ____

Bridge Supply Rx*

(optional for commercially insured patients)

ZEPOSIA® (ozanimod) 0.92 mg capsules once daily:
☐ 30-day supply followed by up to 11 refills

*Please see additional eligibility requirements and Terms and Conditions on page 4.

7: PRESCRIBER AUTHORIZATION†

I certify that (1) I have prescribed ZEPOSIA based on my professional judgment of medical necessity and that I will supervise the patient's medical treatment; (2) I have the authority to disclose this patient's information to BMS and its respective agents and service providers, including the dispensing pharmacy, and I have obtained this patient's authorization for the disclosure, if required by HIPAA or other applicable privacy laws; (3) the information provided is accurate to the best of my knowledge; and (4) I will not seek reimbursement for any free product provided to the patient. I authorize the ZEPOSIA 360 Support Program to transmit the prescription(s) below by any means under applicable law to the appropriate dispensing pharmacy. I understand the information I provide may be used by BMS and parties acting on its behalf for services, communications, marketing, and analytics activities.

†If required by applicable law, please attach copies of all prescriptions on official state prescription forms.

X ____ **Prescriber Signature (Dispense as Written)**

OR ____ **Prescriber Signature (Substitutions Allowed)**

Date ____ **(MM/DD/YY)**

ZEPOSIA 360 SUPPORT™ FAX: 1-833-727-7701 | PHONE: 1-833-ZEPOSIA (833-937-6742) *Call for assistance with completing this form.*

Please see full Prescribing Information and Medication Guide.

PATIENT AUTHORIZATION AND AGREEMENT

The Bristol-Myers Squibb Company ZEPOSIA 360 Support™ program is a support program by Bristol-Myers Squibb Company (BMS) that helps patients understand their insurance coverage and financial support options for ZEPOSIA® (ozanimod), as well as educational, nurse, lab, and diagnostic support services and free medication to qualified patients (the "Program"). To participate in the Program, BMS will need to receive, use, and disclose your personal information. You also have the option to participate in the ZEPOSIA 360 Support Co-pay Assistance Program by separately enrolling below. Please read this authorization carefully, and contact ZEPOSIA 360 Support at 1-833-ZEPOSIA (833-937-6742) if you have any questions. Once you have read and agreed to this form, fax your signed copy to 833-727-7701.

1. What information will be used and disclosed?
My personal information will be disclosed, including: The information on the Program enrollment form; my contact information, date of birth, and phone carrier/device information (for calls and texts); professional and employment information, financial and income information, insurance information, health records and information, including diagnoses, medications, and lab tests and biometric and 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 health caretakers, which include my healthcare providers, pharmacies, lab service providers, diagnostic service providers, health plans, and health insurers who provide services to me, as well as other people who I say can help me apply, to disclose my personal information to BMS, the third parties it works with, and other authorized agents, subsidiaries, and assignees (collectively "BMS"). BMS may also share my information with my health 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 Program and provide services to me, including verifying my insurance benefits, assistance with prior authorizations from my insurance, researching alternative insurance coverage options, providing information and education about the services through a case manager, and referring me and my health caretakers to other plans, support, or assistance programs that may be able to help me with access to my medication, including screenings for other financial assistance options such as medication co-pay assistance
- Provide me with healthcare services, including lab and diagnostic tests and related healthcare procedures related to ZEPOSIA. I understand these healthcare services are not provided, or employed, by my healthcare professional. I understand that my insurance may be billed for these services and that I may have a separate co-pay or cost-sharing obligation for using these services
- Provide free medication to me, if I am eligible
- Receive and/or purchase my information (including information about my prescriptions and insurance claims) from my health caretakers to determine if and where I am receiving my medication and whether I am no longer eligible for free medication or other BMS support programs
- Contact my health 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
- Contact me for marketing purposes, including providing me with information about my medication, refill reminders, surveys, and other information and alerts that BMS believes may be of interest to me (and some of which may be sent directly to my phone if I choose)
- Improve or develop the Program's services and other internal business purposes, including analytics
- BMS also may use my health information to combine it with other information BMS may collect about me and my ZEPOSIA treatment and use it for the purposes described above

Authorization for Sale of My Information to BMS:
I authorize my health caretakers (including my healthcare providers, health plans, health insurers, pharmacies, lab service providers, and diagnostic service providers) to disclose my information for the purposes described in this authorization, and I further authorize my health caretakers to accept payment from BMS in exchange for providing my information as well as providing me with marketing and patient support 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 by writing to: ZEPOSIA 360 Support, PO Box 29062, Phoenix, AZ 85038-9062. If I cancel this authorization, I will no longer be able to participate in the Program. The 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 re-apply at least every year, sign this authorization again, and be accepted.

5. Notices: I understand that once my health information has been disclosed, privacy laws may no longer restrict its use, disclosure, or further re-disclosures. 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

PATIENT AUTHORIZATION AND AGREEMENT

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 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 1-833-ZEPOSIA (833-937-6742) or complete the online form at www.bms.com/dpo/us/request.

PATIENT AUTHORIZATION AND AGREEMENT SIGNATURE

I have read the Patient Authorization and Agreement and agree to its terms.

Print name of patient or personal representative _____ **DOB** _____

Representative's relationship to patient _____ **Preferred e-mail** _____

Signature of patient or patient representative: X _____ **Date** _____

Program Terms: In order to provide Access Assistance, patients must provide information that is true and complete. At any time during participation, BMS may request additional documentation to verify the patient's personal information. If there is missing information or the patient does not respond to requests for additional information, BMS may delay or terminate participation. Additional terms apply for co-pay assistance and free medication. BMS may discontinue the Program or change the rules for participation at any time, without any notice.

☐ **Yes, I consent to receive text messages.** *I have read the Terms and Conditions and agreed to receive text messages and calls as explained in the consent for automated texts and calls.*

Consent for autodialed calls and texts (optional): I authorize the receipt of autodialed calls and text messages from BMS and the Program. I understand that my authorization is not a condition of purchase, or use, of ZEPOSIA® (ozanimod) or any other BMS products and that the Program's services are valid with most major US carriers. I understand that my carrier's message and data rates may apply. I understand that information BMS obtains from me in connection with use of autodialed calls and text messages is used by the Program under the terms of this authorization. I can stop autodialed calls and text messages at any time by calling ZEPOSIA 360 Support™ at 1-833-ZEPOSIA (833-937-6742). I can also stop text messages by texting "STOP" to the phone number from which I received a text message. For help, I can text "HELP" to the phone number from which I received a text message.

ZEPOSIA 360 CO-PAY ASSISTANCE PROGRAM

If eligible, I would like to enroll in the ZEPOSIA Co-pay Assistance Program. I have read the co-pay terms and conditions (pg 4) and agree to its terms.

The ZEPOSIA Co-pay Assistance Program is a support program that provides eligible patients with co-pay assistance, reminders, surveys, and other patient support information for ZEPOSIA and related disease information. I understand that the information I provide, along with information about my use of the support program services will be stored and used by Bristol Myers Squibb and parties acting on its behalf ("BMS") to provide the support services to me and the caregivers/alternate contacts that are listed on this form or that I otherwise designate in writing. BMS may also store and use my information to contact me and my designated caregivers/alternate contacts via mail, telephone, in electronic format or otherwise about products, services, market research, clinical trials, and other information and offers that it believes to be of interest to me. BMS may also use my information in order to improve or develop its services and for other internal business purposes including analytics, communication services, and marketing activities. BMS also may use my information to combine it with other information BMS may collect about me and my treatment and use it for the purposes described above. Use of my information will be governed by the BMS Privacy Policy. From time to time the Privacy Policy may change and I understand that I should check the website at www.bms.com for the most recent version. I can stop future marketing communications and use of my information by calling 1-833-ZEPOSIA (833-937-6742).

Patient or patient representative signature: X _____ **Date** _____

Print name of patient or personal representative _____

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 1-833-727-7701 or call 1-833-937-6742 for further assistance. **NOTE: Enrollment cannot be processed without a valid signature.**
The patient or their representative must be provided with a copy of this Patient Authorization and Agreement Form after it has been signed.

Prefer to authorize your consent online? Visit **ZEPOSIA.COM/ESIGN** to submit your signature electronically.
(Note: This page of the form must still be completed and returned by fax to 1-833-727-7701)

To receive co-pay assistance or free medication from BMS, patients must comply with the Program rules, and they may not be reimbursed for the assistance patients received from anyone else, including from an insurance program, another charity, or from a health savings, flexible spending, or other health reimbursement account. Assistance may be temporary, and patients may be required to apply every year. Patients must contact the Program at 1-833-937-6742 if their insurance or treatment changes in any way. Medicare Part D patients may not count any free medication received toward their true out-of-pocket (TrOOP) costs.

SCREENING ASSISTANCE FOR ASSESSMENTS

Available for on-label commercially insured patients only. This offer is not valid for medical screenings for which payment may be made in whole or in part under federal or state health programs, including but not limited to Medicare or Medicaid, and for residents in RI. This program is subject to termination or modification at any time.

ZEPOSIA FREE TRIAL OFFER

Patient must have a valid prescription for ZEPOSIA for an FDA-approved indication. Patient must be new to therapy and have not previously received a sample or filled a prescription for ZEPOSIA. Patient is responsible for applicable taxes, if any. This offer is limited to one use per patient per lifetime and is non-transferable. Cannot be combined with any other rebate/coupon, free trial, or similar offer. No substitutions permitted. Patients, pharmacists, and prescribers cannot seek reimbursement for the ZEPOSIA Free Trial from health insurance or any third party, including state or federally funded programs. Patients may not count the ZEPOSIA Free Trial as an expense incurred for purposes of determining out-of-pocket costs for any plan, including Medicare Part D true out-of-pocket costs (TrOOP). Offer is not conditioned on any past, present, or future purchase, including refills. Only valid in the United States and US Territories. Void where prohibited by law or restricted. The Program is not insurance. Bristol Myers Squibb reserves the right to rescind, revoke, or amend this offer at any time without notice.

BRIDGE PROGRAM

The Bridge Program is available at no cost for eligible, commercially insured, on-label diagnosed patients if there is a delay in determining whether commercial prescription coverage is available, and is not contingent on any purchase requirement, for up to 24 months (dispensed in 30-day increments). The Bridge Program is not available to patients who have prescription insurance coverage through a state or federal healthcare program, including but not limited to Medicare, Medicaid, Medigap, CHAMPUS, TRICARE, Veterans Affairs (VA), or Department of Defense (DoD) programs and is available for no more than 12 months to patients in MA, MN, and RI. Appeal of any prior authorization denial must be made within 90 days, or as per payer guidelines, to remain in the program. Eligibility will be re-verified in January for patients continuing into the following year, and may be at other times during program participation. Offer is not health insurance. Once coverage is approved by the patient's commercial insurance plan, the patient will no longer be eligible. Void where prohibited by law, taxed, or restricted. Bristol-Myers Squibb Company reserves the right to rescind, revoke, or amend this program at any time without notice. Other limitations may apply.

ZEPOSIA 360 CO-PAY ASSISTANCE PROGRAM

1. ZEPOSIA Co-pay Program is valid only for patients with commercial insurance. The Program includes a prescription benefit offer for out-of-pocket drug costs and a medical assessment benefit offer for out-of-pocket costs for the initial blood tests, ECG screening, and eye exam where the full cost is not covered by patient's insurance.
2. Patients are not eligible for the prescription benefit offer if they have prescription insurance coverage through a state or federal healthcare program, including but not limited to Medicare, Medicaid, Medigap, CHAMPUS, TRICARE, Veterans Affairs (VA), or Department of Defense (DoD) programs.
3. Patients are not eligible for the medical assessment benefit offer if they have insurance coverage for their prescription or medical assessment through a state or federal healthcare program, or reside in Massachusetts, Minnesota, or Rhode Island. Patients who move from commercial plans to state or federal healthcare programs will no longer be eligible.
4. Patients must be 18 years of age or older.
5. Patients may pay as little as $0 in out-of-pocket costs per prescription, subject to a maximum benefit of $18,000 during a calendar year. Patients may pay as little as $0 in out-of-pocket costs for the medical assessment, subject to a maximum benefit of $2,000. The medical benefit offer only applies to clinical baseline assessment services covered by the Program. Patients are responsible for any costs that exceed the maximum amounts.
6. To receive the medical assessment benefit, an Explanation of Benefits (EOB) form must be submitted, along with copies of receipts for any payments made.
7. The Program expires on December 31, 2024.
8. All Program payments are for the benefit of the patient only.
9. Patients, pharmacists, and prescribers may not seek reimbursement from health insurance, health savings or flexible spending accounts, or any third party, for any part of the prescription or medical assessment benefit received by the patient through this Program.
10. Patient's acceptance of any Program benefit confirms that it is consistent with patient's insurance and that patient will report the value received as may be required by his/her insurance provider.
11. Program valid only in the United States and Puerto Rico. Void where prohibited by law, taxed, or restricted.
12. The Program cannot be combined with any other offer, rebate, coupon, or free trial. The Program is not conditioned on any past, present or future purchase, including refills.
13. The Program is not insurance. Other limitations may apply.
14. Bristol Myers Squibb reserves the right to rescind, revoke, or amend this Program at any time without notice.