



**BRISTOL-MYERS SQUIBB PATIENT ASSISTANCE FOUNDATION, INC.
ABILIFY PATIENT ASSISTANCE PROGRAM**

**P.O. Box 8309
Somerville, NJ 08876
Phone: (800) 736-0003
Fax: (866) 598-5561**

Dear Applicant,

Thank you for your interest in the Bristol-Myers Squibb Patient Assistance Foundation (BMSPAF) Program. Enclosed you will find the application form you had requested.

To participate in our program, it is important that you complete all requested information and sign where indicated. Incomplete applications will be returned.

PATIENT REQUIREMENTS:

- ✓ Complete and sign the Patient Information section. Household size is the number of persons living in the home.
- ✓ Attach a photocopy of the ANNUAL household income. (Federal tax form (1040), social security income (SSA 1099), pensions, interest, retirement, child support. If you have no (zero) income, please provide a letter verifying your income status from your healthcare provider, shelter or patient advocate.)

INCOME ELIGIBILITY CRITERIA REQUIREMENTS:

For 2010, based on household size, patient’s income must not exceed income criteria listed below:

Size of Family Unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$27,075	\$33,825	\$31,150
2	\$36,425	\$45,525	\$41,900
3	\$45,775	\$57,225	\$52,650
4	\$55,125	\$68,925	\$63,400
5	\$64,475	\$80,625	\$74,150
For each additional person, add	\$9,350	\$11,700	\$10,750

HEALTHCARE PROVIDER REQUIREMENTS:

- ✓ Complete and sign the Healthcare Provider section. There is no need to include a prescription.
- ✓ **Provide your State License Number in order to process the application.**
- ✓ Complete the section for RX instructions; including drug name, strength and quantity per day
- ✓ List a shipping address for your physical office address. Cannot ship to a patient’s home or a P.O. Box.
- ✓ Complete the ENTIRE application. When requesting a change of dosage for an existing patient, indicate “YES” on the “change to dosing schedule” portion of the application and provide the new prescription instructions.

SUBMIT COMPLETED APPLICATIONS BY SELECTING ONE OF THE FOLLOWING OPTIONS:

- ✓ MAIL: Abilify Patient Assistance Program
P.O. Box 8309
Somerville, NJ 08876
- ✓ FAX: 1-866-598-5561 (Please DO NOT fax multiple submissions of the application)

You will be notified by mail upon completion of our review and evaluation. Please note, program rules are subject to change without notice. If you have questions or need further assistance, please call 1-800-736-0003, between 9:00 AM and 6:00 PM Eastern Time, Monday through Friday.

Sincerely,
Bristol-Myers Squibb
Patient Assistance Foundation, Inc.
Enclosure



BRISTOL-MYERS SQUIBB PATIENT ASSISTANCE FOUNDATION, INC.
ABILIFY PATIENT ASSISTANCE PROGRAM
P.O. Box 8309 | Somerville, NJ 08876 | Phone: (800) 736-0003 | Fax: (866) 598-5561



PATIENT INFORMATION

First Name:	MI:	Last Name:	Date of Birth: / /
Mailing Address:			Apt #:
City:	State:	Zip Code:	
Social Security Number:		Phone number: ()	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>		Contact Name:	

PATIENT ELIGIBILITY INFORMATION – ATTACH PROOF OF ANNUAL HOUSEHOLD INCOME (REQUIRED)

TOTAL ANNUAL HOUSEHOLD INCOME (Include all annual Income, Wages, Social Security, Pension, Disability, Interest Earned on Savings, etc.) \$ _____

Household Size (number of persons living in the home):	Is patient a U.S. Citizen or legal resident? Yes <input type="checkbox"/> No <input type="checkbox"/>
Private Insurance	Yes <input type="checkbox"/> No <input type="checkbox"/> Medicare A Yes <input type="checkbox"/> No <input type="checkbox"/>
Prescription Drug Coverage	Yes <input type="checkbox"/> No <input type="checkbox"/> Medicare B Yes <input type="checkbox"/> No <input type="checkbox"/>
Medicaid	Yes <input type="checkbox"/> No <input type="checkbox"/> Medicare D Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you applied for Medicaid in the past and been denied?	Yes <input type="checkbox"/> No <input type="checkbox"/> VA or Military Benefits Yes <input type="checkbox"/> No <input type="checkbox"/>

I attest that the above information is complete and accurate. I attest that I have no prescription insurance coverage for the indicated medication, including Medicaid, Medicare or any other public or private program and I have insufficient financial resources to pay for the prescribed therapy. By my signature, I authorize the release of information about me and my medical condition to the Bristol-Myers Squibb Patient Assistance Foundation (BMSPAF), and/or their agents. I authorize the BMSPAF, and/or their agents to use and disclose such information for the assessment of my eligibility for, enrollment into the BMSPAF and administration of the BMSPAF, which may include contacting my insurer, public funding programs, social workers, advocacy organizations, healthcare providers, or other persons or entities the BMSPAF may deem appropriate, to release all medical records or requested information bearing on my eligibility to and benefits under the program. Additionally, I agree that at any time during my enrollment, the BMSPAF may request additional documentation to authenticate the statements made on my application. The BMSPAF and/or their agents agree not to disclose any information to any third party except as authorized by me or as required by law. I understand and acknowledge that this assistance is temporary and that this program may be changed or discontinued at any time without notice. I understand that the BMSPAF, and/or their agents are relying on this information.

Patient Signature: _____ Date: _____
Advocate Signature: _____ Date: _____

HEALTHCARE PROVIDER INFORMATION TO BE COMPLETED BY THE PRESCRIBING PRACTITIONER

First Name:	Last Name:	Professional Designation:
State License Number:		
Shipping Address 1: (cannot ship to P.O. Box)		
Shipping Address 2:		
City	State:	Zip Code: Diagnosis Code:
Contact Name:	Phone Number: ()	Fax: ()

REQUESTED MEDICATION (PLEASE CHOOSE):

<input type="checkbox"/> Abilify Oral Solution 150 mL _____ Qty / Day	<input type="checkbox"/> Abilify 2mg _____ Qty / Day	<input type="checkbox"/> Abilify 5mg _____ Qty / Day	<input type="checkbox"/> Abilify 10 mg _____ Qty / Day	<input type="checkbox"/> Abilify 15mg _____ Qty / Day	<input type="checkbox"/> Abilify 20 mg _____ Qty / Day	<input type="checkbox"/> Abilify 30 mg _____ Qty / Day
<input type="checkbox"/> Abilify 10mg DISCMELT® _____ Qty / Day	<input type="checkbox"/> Abilify 15mg DISCMELT® _____ Qty / Day	Is this a change in dose schedule for an existing BMSPAF member? <input type="checkbox"/> YES <input type="checkbox"/> NO				

I represent that any information I have provided about this patient is complete, accurate and consistent with applicable privacy laws and regulations, and I understand that the BMSPAF, and/or their agents are relying on this information. To the best of my knowledge, this patient has no prescription insurance coverage for the indicated medication, including Medicaid, Medicare or other public or private programs. I acknowledge and agree not to submit an insurance claim or other claim for payment to any third-party payor (private or government) for the medication. I understand that BMSPAF reserves the right to modify or terminate this program at any time. My signature certifies that the medication received from BMSPAF will not be resold nor offered for sale, trade or barter and will not be returned for credit. I understand that BMSPAF reserves the right to recall or discontinue product at any time without notice.

Healthcare Provider Signature: _____ Date: _____

