SOTYKTU 360 SUPPORT
Your circle of support

PHONE: 1-888-SOTYKTU (1-888-768-9588)
FAX: 1-888-381-0029

www.SOTYKTU.com
sotyktuhcp.com/startformupload

SOTYKTU (deucravacitinib) 6 mg tablets

Section A: Patient information

Patients: Please fill out this section and read the Patient Authorization & Agreement on pages 2-3. You need to sign the Patient Authorization & Agreement on page 3 in order to submit and enroll in SOTYKTU 360 Support. If any information or your signature is missing, it may cause delays in filling your prescription and signing you up for the Patient Support Program.

First name | Middle initial | Last name | DOB

Street address | City | State | ZIP

Mobile phone | Home phone | OK to leave voicemail? ☐ Yes ☐ No

Email | Preferred language: ☐ English ☐ Spanish ☐ Other | Gender

Prescription drug insurance: ☐ Check here if you do not have prescription drug insurance

Primary pharmacy carrier | Phone #

Rx member ID | Rx group ID *(optional)*

Rx BIN # | Rx PCN #

Medical insurance: Primary insurance carrier | Policy ID #

Best time to contact: ☐ Morning ☐ Afternoon ☐ Evening

HCPs: Please make a **copy of patient insurance card(s),** front and back, and **attach to this document.**

Section B: Healthcare provider information

HCPs: Please fill out the following sections and **sign and date this page.** If any information or your signature/date is missing, it may cause delays. **Fax COMPLETED pages 1-3.**

First and last name | NPI # | State license #

Practice/ clinic | Phone | Fax

Address | City | State | ZIP

Primary office contact name | Primary office contact phone | Primary office contact fax

Best time to contact: ☐ Morning ☐ Afternoon

Section C: Clinical information

DIAGNOSIS: ☒ Plaque psoriasis (PsO) (ICD-10-CM Code: L40.0) ☐ Other

Date of diagnosis | Prior therapies

Drug allergies | ☐ No known drug allergies

Section D: Prescription information

Patient name | DOB

SELECT MAINTENANCE DOSE **Maintenance Rx for SOTYKTU 6 mg**

☐ 1 tablet orally once daily, 30 day supply

Refills: ☐ 11 ☐ Other amount

SELECT BRIDGE* **Bridge Rx for SOTYKTU 6 mg**

Optional for commercially insured patients

☐ 1 tablet orally once daily, 30 day supply

Refills: ☐ 11 **OR** ☐ Other amount

☐ **Provider has a preferred specialty pharmacy** ☐ **Provider has sent prescription to the preferred specialty pharmacy** | Preferred specialty pharmacy name

*Please see additional eligibility requirements and terms and conditions on page 4.

Section E: Prescriber authorization

I certify that (1) I have prescribed SOTYKTU 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; (4) I will not seek reimbursement for any free product provided to the patient; and (5) I have read and will comply with the Program terms and conditions on page 4. I authorize the SOTYKTU Support Program to transmit the prescription(s) above 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. If you are in the state of AZ, FL, IA, or NY, please also send an electronic prescription (eRx) or fax prescription directly to the pharmacy for each prescription selected.

PRESCRIBER SIGNATURE | **OR** | **Date**

Dispense as written | **Substitutions allowed**

Signature stamps not acceptable. The prescriber is to comply with their state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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

Patients: Please read the Patient Authorization & Agreement below. You need to sign the Patient Authorization & Agreement in order to submit and enroll in SOTYKTU 360 Support. If your signature is missing, it may cause delays in filling your prescription and signing you up for the Patient Support Program.

Patient Authorization & Agreement

The patient support program for SOTYKTU (deucravacitinib) (the "Program") is designed to help patients understand their insurance coverage and financial support options as well as provide free medication for those who qualify. To participate in the Program, Bristol Myers Squibb will need to receive, use, and disclose your personal information.

Please read this form carefully. For questions, contact us at 1-888-SOTYKTU (1-888-768-9588).

What information will be used and disclosed?

My personal information will be used and disclosed, including the information on this form, my contact information, date of birth, health information, and health records (including diagnoses, medications, lab tests, and biometric information, etc.), and insurance information.

Who will disclose, receive, and use the information?

This authorization permits my healthcare providers, pharmacists, health plans, and health insurers who provide services to me ("my Health Caretakers") to disclose my personal information to BMS and its authorized agents, subsidiaries, and assignees (collectively, "BMS"). BMS may also share my information with my Health Caretakers and other healthcare providers, pharmacists, health insurers, and charitable organizations to determine if I am eligible for, or enrolled in, another plan or program.

What is the purpose for the use and disclosure?

My personal information will be used by, and shared with, the persons and organizations described above in order to process my application and provide the Program's services to me, including to:

- Verify my insurance benefits, research insurance coverage options, and determine my eligibility for BMS co-pay assistance programs
- Contact other healthcare providers and charitable organizations to determine if I'm eligible for, or enrolled in, another plan or program
- Contact me and my Health Caretakers about other programs and services that are available, including screenings for other financial assistance options
- Provide free medication to me if I qualify
- 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 me for marketing purposes, including providing me with information about my medication, refill reminders, surveys, research studies, 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
- Use my health information to combine it with other information BMS may collect about me and my 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.

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 also cancel this authorization in the future by writing to: Bristol Myers Squibb, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560

Notices. I understand that once my health information has been disclosed to the Program, privacy laws may no longer restrict its use or disclosure. If I cancel this authorization, the Program will stop using or disclosing my information for the purposes listed here, except as allowed or required by law or as necessary to end my participation in the Program. I also have a right to receive a copy of this form after I have signed it. The Program agrees to use and disclose my information only for the purposes described in this authorization or as allowed or required by law. BMS will not sell or rent personal information collected about me from this Program. 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 BMS may not respond or address my request beyond 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 BMS will honor a request to provide access to, or deletion of, my information. BMS will not discriminate against me for exercising my rights, but I understand that they may not be able to provide me with Program services if they are not able to use my information. To submit an access or deletion request with respect to the Program, I may call 855-961-0474 or complete the online form at: www.bms.com/dpo/us/request

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

(continued on next page)

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 if the patient does not respond to requests for additional information, BMS may delay or terminate participation. To receive free medication from BMS, patients must comply with the Program rules provided on the enrollment form and patients may not be reimbursed for the assistance 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 1-888-SOTYKTU (1-888-768-9588) 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. BMS may discontinue the Program or change the rules for participation at any time, without any notice.

I have read the patient authorization and agree to its terms.

Print name of patient or patient representative

Representative's relationship to patient

Preferred email

SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE

Today's date

DOB

The patient or his/her representative must be provided with a copy of this Patient Authorization and Agreement Form after it has been signed. NOTE: Enrollment cannot be processed without a valid signature. Power of Attorney documentation required if someone other than the patient signs. Fax documents to 1-888-381-0029 or call 1-888-SOTYKTU (1-888-768-9588) for further assistance.

☐ **YES, I CONSENT TO RECEIVE TEXT MESSAGES.** I have read and agreed to receive text messages and calls as explained in the consent for auto-dialed texts and calls.

By checking this box, I, the patient identified in the signature box above, agree to receive auto-dialed text messages or telephone calls by or on behalf of BMS and to the terms of this mobile program (visit sotyktu.com/terms-conditions) at the telephone number I have provided. I understand I will receive informational and telemarketing telephone calls and text messages relating to any BMS patient support program in which I may be enrolled, including but not limited to the Program. [The number of messages you receive will vary based on your responses.] Consent is not a condition of purchase or use of any BMS product. Text messaging is available with most major US carriers. If my mobile phone number changes in the future, I agree to promptly notify BMS at 1-888-768-9588. Message and data rates may apply. I can opt-out at any time by texting STOP to 87861 and texting HELP to receive more information. I understand that I will receive one final text confirming my opt-out request.

SOTYKTU Patient Support Program

The SOTYKTU Co-Pay Assistance Program is a support program that provides eligible patients with co-pay assistance, reminders, surveys, and other information about SOTYKTU. I understand that the information I provide, along with information about my use of the Program services, will be stored and used by Bristol Myers Squibb and parties acting on its behalf ("BMS") to provide the services to me. BMS may also store and use my information to contact me 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 SOTYKTU treatments 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 1-888-768-9588.
By signing below, I agree that I have read and agree to the terms and conditions of the Program.

SOTYKTU Co-Pay Assistance Program: Sign below to enroll.
I have read and agree to the to the terms and conditions of the Program.

Print name

SIGNATURE OF PATIENT

Today's date

Save our Contact Number

Scan this code to add our number to your phone—that way you'll always know when it's your SOTYKTU Support Coordinator calling. To do it manually, create a new "SOTYKTU 360 SUPPORT" contact on your phone with this number: 1-888-SOTYKTU (768-9588).

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

SOTYKTU Bridge Program

Eligibility requirements

To be eligible for the SOTYKTU Bridge Program for SOTYKTU (deucravacitinib):

- A SOTYKTU prescription for an FDA-approved use
- Commercial insurance with coverage
- Payer coverage denial or delay of five (5) days post Prior Authorization (PA) submission
- Submitting an Appeal/Exception/Letter of Medical Necessity (LMN) to challenge PA payer outcome within 90 days or per payer guidelines of PA outcome if coverage is denied
- Program requires a periodic check of your insurance coverage status to confirm your continued eligibility, including, but not limited to the annual reverification process. Program is available until your commercial insurance covers your medication for up to 24 months (dispensed in 30-day prescriptions)
- A signed Patient Authorization and Agreement (PAA) is on file
- Residents of the US and US Territories only
- SOTYKTU Bridge Program is not available to patients who have prescription insurance coverage through Medicare, Medicaid, or any other federal or state program

Bridge to commercial coverage offer:

The SOTYKTU Bridge Program is available at no cost for eligible, commercially insured, on-label diagnosed patients and whose prior authorization is denied or delayed, and is not contingent on any purchase requirement, for up to 24 months (dispensed in 30-day prescriptions). The prescriber has certified that therapy with SOTYKTU is medically necessary for this patient and will be supervising the patient's treatment accordingly.

The SOTYKTU Bridge Program is not available to patients who have prescription insurance coverage through Medicare, Medicaid, or any other federal or state program. 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 on a rolling 12 month basis from the patient's first shipment date, and may be re-verified at other times during Program participation.

Offer is not health insurance, and may be modified or discontinued at any time without notice. Once coverage is approved by the patient's commercial insurance plan, the patient will no longer be eligible. Other limitations may apply. Bristol Myers Squibb reserves the right to rescind, revoke, or amend the Program at any time without notice.

SOTYKTU Co-Pay Assistance Program Terms & Conditions

Eligibility Requirements and Program Benefits

- Patients must have commercial (private) insurance, but their coverage does not cover the full cost of the prescription. Co-pay assistance is not valid where the entire cost of the prescription is reimbursed by insurance
- Patients are not eligible 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; patients who move from commercial to state or federal healthcare program insurance will no longer be eligible
- Cash-paying patients are not eligible for co-pay assistance
- Patients must be 18 years of age or older
- Patients must live in the United States or United States territories
- Eligible patients with an activated co-pay card and a valid prescription may pay as little as $0 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

Program timing

- Patients will be evaluated for ongoing eligibility to continue enrollment in the program. In the event patients experience a change in insurance coverage or BMS 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

Additional terms & conditions

- 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 benefit received by the patient through this offer
- 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 patient's insurance provider
- All Program payments are for the benefit of the patient only
- Offer valid only in the United States and United States territories
- Void where prohibited by law, taxed, or restricted
- The Program is not insurance
- The Program benefits are not transferable and is limited to one (1) per patient. This offer cannot be combined with any other offer, rebate, coupon, or free trial
- This Program is not conditioned on any past, present, or future purchase, including additional doses
- No membership fees
- Bristol Myers Squibb reserves the right to rescind, revoke, or amend this offer at any time without notice

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

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