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

NEUROLOGY START FORM INSTRUCTIONS

INSTRUCTIONS FOR PATIENTS

HOW TO GET STARTED WITH ZEPOSIA

1. **Read the Patient Authorization and Agreement on pages 1 and 2. And don't forget to:**
   - Provide your name, signature, and date as indicated on page 2. If you prefer, to authorize your consent online, visit zeposia.com/esign
   - Check the box on page 2 to enroll in the ZEPOSIA co-pay offer (if eligible)
   - Check the box on page 2 to be a part of the ZEPOSIA 360 Support™ mobile program to receive important updates and information straight to your mobile device
2. **Fill out your information on page 3 of the Start Form. Be sure to complete sections 1, 2, and 3.**
3. **Your healthcare provider will fill out the rest of this form.** They'll complete page 4 of the Start Form and fax the completed version (pages 2, 3, and 4) to ZEPOSIA 360 Support.

WHAT TO EXPECT NEXT

1. You'll receive a phone call from a Nurse Navigator at ZEPOSIA 360 Support, a welcome email, and a text if you indicated you'd like to receive text messages.
2. Your Nurse Navigator will go over the next steps with you to help you get started.

If you don't hear from us, please reach out by calling the ZEPOSIA 360 Support program phone number below.

INSTRUCTIONS FOR HEALTHCARE PROVIDERS

HOW TO PRESCRIBE ZEPOSIA

1. **Once you've decided ZEPOSIA is right for your patient:**
   - Have your patient read the Patient Authorization and Agreement on pages 1 and 2
   - Ensure your patient provides their name, signature, and date on page 2 and completes the required fields on page 3 of the Start Form. If preferred, patients can authorize consent online at zeposia.com/esign
2. **Fill out page 4 of the Start Form and sign where designated.** Be sure to complete sections 4 through 7 of this form and provide your signature and the date where indicated.
3. **Complete and fax pages 2, 3, and 4 to 1-833-727-7702.** Don't forget to double-check this form to make sure you and your patient have completed each field as required.
4. **Direct your patient to call ZEPOSIA 360 Support with any questions.** A Nurse Navigator will be available to answer questions and discuss next steps with your patient to help them get started with ZEPOSIA.

For questions, call:

ZEPOSIA 360 Support at **1-833-ZEPOSIA** (833-937-6742), Monday to Friday, 8 AM - 8 PM ET **or visit ZEPOSIA.com**

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), provides co-pay and free medication support to qualified patients, and provides educational, nurse, lab, and diagnostic support services. To participate in the Program, BMS will need to receive, use, and disclose your personal information. 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 833-727-7702.

1. What information will be used and disclosed?
My personal information will be disclosed, including:

- Information on the Program enrollment form
- Contact information and phone carrier/device information (for calls and texts)
- Date of birth and Social Security Number (SSN is voluntary)
- Professional and employment information
- Financial and income information
- Insurance information
- Health records and information, including diagnoses, medications, and lab tests
- 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 ZEPOSIA 360 Support services and provide the Program 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
- 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 co-pay assistance and/or 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

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.

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 220734, Charlotte, NC 28222. 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 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.

TO HEALTHCARE PROVIDER: Fax the completed pages 2, 3, and 4, a copy of insurance card, and pharmacy benefit card (both sides of each) to **1-833-727-7702** or enroll online at **www.ZEPOSIAportal.com**

PATIENT AUTHORIZATION AND AGREEMENT

6. Patient certifications: I certify that the personal information that I provide to BMS is true and complete. I agree that, at any time during my participation, BMS may request additional documentation to verify my personal information. If there is missing information or I do not respond to requests for additional documents, my participation may be delayed or I may no longer be able to participate. If I qualify for, and receive, co-pay assistance or free medication assistance from BMS, I agree to comply with the Program rules on your enrollment form and I will not get reimbursed for the assistance I receive from anyone else, including from an insurance program, another charity, or a health savings, flexible spending, or other health reimbursement account. I understand that assistance may be temporary and that I may be required to apply every year. I will contact the Program at 1-833-937-6742 if my insurance or treatment changes in any way. If I have Medicare Part D, I will also not count any free medication I receive toward my true out-of-pocket (TrOOP) costs. I understand that the Program may be discontinued or the rules for participation may change at any time without notice.

7. Consent for autodialed calls and texts (optional): I authorize the receipt of autodialed calls and text messages from the Program. I understand that my authorization is not a condition of purchase, or use, of ZEPOSIA® (ozanimod) or any other BMS product and that the Program is 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 763-600-7990 or the phone number from which I received a text message. For help, I can text "HELP" to 763-600-7990 or the phone number from which I received a text message.

The patient or his/her personal representative must be provided with a copy of both pages of this form after it has been signed.

ZEPOSIA CO-PAY PROGRAM TERMS AND CONDITIONS

1. The ZEPOSIA Co-pay Program is valid only for patients with commercial (private) insurance prescribed ZEPOSIA® (ozanimod) for an FDA-approved indication. 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, and ECG screening where the full cost is not covered by the 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. 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, Michigan, Minnesota, or Rhode Island. Patients who move from commercial plans to state or federal healthcare programs will no longer be eligible. **3.** Patient must be 18 years of age or older. **4.** Patients 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 pay as little as $0 in out-of-pocket costs for the medical assessment, subject to a maximum benefit of $2,000. Patients are responsible for any costs that exceed the maximum amounts. **5.** To receive the medical assessment benefit, an Explanation of Benefits (EOB) form must be submitted, along with copies of receipts for any payments made. This benefit is available without obligation to continue with ZEPOSIA therapy. **6.** The Program expires on December 31, 2021. **7.** All Program payments are for the benefit of the patient only. **8.** 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. **9.** Patient's acceptance of any Program benefit confirms that it is consistent with the patient's insurance and that the patient will report the value received as may be required by his/her insurance provider. **10.** Program valid only in the United States and Puerto Rico. Void where prohibited by law, taxed, or restricted. **11.** The Program cannot be combined with any other offer, rebate, coupon, or free trial. **12.** The Program is not conditioned on any past, present, or future purchase, including refills. **13.** The Program is not insurance. **14.** Bristol-Myers Squibb Company reserves the right to rescind, revoke, or amend this Program at any time without notice.

PATIENT APPROVAL

NOTE: Enrollment cannot be processed without valid signature.

☐ **If eligible, I would like to enroll in the ZEPOSIA Co-pay Program.**
I have read and agreed to the program terms and conditions above, and understand that co-pay assistance is only available for commercially insured patients and does not apply if I have prescription drug coverage through a federal, state, VA, or similar program.

☐ **I would like to receive text messages and calls.**
I have read and agreed to receive text messages and calls as explained in the Consent for autodialed calls and texts (see above).

I have read and agreed to the Patient Authorization and Agreement on pages 1 and 2 of this form.

Patient: ⓘ **First name** _____ ⓘ **Last name** _____ ⓘ **Date of birth** ____/____/____

ⓘ **Patient or patient's personal representative's signature:** X _____ ⓘ **Date** ____/____/____

Patient's personal representative: Full name _____

Description of authority _____

Prefer to authorize your consent online? Visit **ZEPOSIA.COM/ESIGN** to submit your signature electronically.
(Note: Page 3 and 4 of this form still needs to be completed and returned, by fax, to 1-833-727-7702.)

Questions? Call 1-833-ZEPOSIA (833-937-6742) for assistance completing the ZEPOSIA Start Form.

NEUROLOGY START FORM

TO HEALTHCARE PROVIDER: Fax the completed pages 2, 3, and 4, a copy of insurance card, and pharmacy benefit card (both sides of each) to **1-833-727-7702** or enroll online at **www.ZEPOSIAportal.com**

PATIENT:

Please provide all information in sections 1 through 3 below. **Be sure to include your name, signature, and date on page 2.**

(!) Indicates a field that MUST be completed for this form to be processed.

1 PATIENT INFORMATION

☐ Male ☐ Female ☐ Other

(!) **First name** _____ **MI** _____ (!) **Last name** _____ (!) **Date of birth** ____/____/_____

Address *(No PO Box)* _____ **City** _____

State _____ **ZIP** _____ (!) **E-mail address** (required for co-pay enrollment)_____

(!) **Mobile phone** _____ **Home phone** _____ **Work phone** _____ ☐ OK to leave voicemail

Preferred contact number: ☐ Mobile ☐ Home ☐ Work **Preferred time:** ☐ Morning ☐ Afternoon ☐ Evening

Preferred language: ☐ English ☐ Spanish ☐ Other _____

Name of care partner/alternate contact* _____

Care partner/alternate contact phone _____ ☐ OK to leave voicemail

Care partner/alternate contact e-mail address _____

*By providing the name and contact information of this individual, I am authorizing the disclosure of my health information to him/her.

2 MEDICAL INSURANCE COVERAGE

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

(!) **Primary insurance carrier** _____ (!) **Policy #** _____

Group # _____ **Insurance phone** _____ **Policyholder name** (First, Last) _____

☐ Patient has no insurance

Secondary insurance carrier _____ **Policy #** _____

Group # _____ **Insurance phone** _____ **Policyholder name** (First, Last) _____

3 PRESCRIPTION INSURANCE COVERAGE

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

Prescription insurance carrier _____ **Rx Member ID** _____ **Insurance phone** _____

Rx PCN (if applicable) _____ **Rx Group ID** _____ **Rx BIN** (if applicable) _____

☐ Patient has no insurance

☐ Patient does not have a separate plan for prescription insurance; these benefits are included in patient's medical insurance plan

Once you've completed this form, please provide your name, signature, and date at the bottom of page 2.

NEUROLOGY START FORM

TO HEALTHCARE PROVIDER: Fax the completed pages 2, 3, and 4, a copy of insurance card, and pharmacy benefit card (both sides of each) to **1-833-727-7702** or enroll online at **www.ZEPOSIAportal.com**

Patient: First name _____ **Last name** _____ **Date of birth** ____/____/____

HEALTHCARE PROVIDER:

Please provide all information in sections 4 through 7 below. (!) Indicates a field that MUST be completed for this form to be processed. If you need help, please call ZEPOSIA 360 Support™ at 1-833-ZEPOSIA (833-937-6742).

4 PRESCRIBER INFORMATION

(!) **First name** _____ (!) **Last name** _____ **Office/Clinic/Institution Name** Abington Neurological Assoc

(!) **Address** 1151 Old York Road, Suite 200 (!) **City** Abington (!) **State** PA (!) **ZIP** 19001

(!) **Phone** 215-957-9250 **Fax** 215-957-9254 (!) **NPI #** _____ (!) **State medical license #** _____

E-mail address _____ **Office contact name** _____ **Best time to contact:** ☐ Morning ☐ Afternoon

Office contact phone _____ **Office contact e-mail address** _____

5 ASSESSMENTS

(!) **Are you requesting assessment assistance?**

NO assistance requested and I confirm (check one):

- ☐ All assessments completed, patient is cleared for therapy
- ☐ Assessments not yet completed, and will be completed by the office. ZEPOSIA 360 Support will follow-up to confirm completion

YES, assistance requested (check all that apply)*:

- **In-home blood tests:** ☐ CBC ☐ LFTs ☐ VZV antibody serology
- **Screenings:** ☐ In-home ECG ☐ Help finding a provider if a macular edema assessment is needed

*Available for on-label commercially insured patients only. This offer is not valid for medical assessments 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 MA, MN, and RI. This program is subject to termination or modification at any time.

6 CLINICAL INFORMATION

(!) **Primary diagnosis:** ☐ ICD 10 G35: (Multiple Sclerosis) ☐ Other _____

Treatment-naive?: ☐ No ☐ Yes

Current/most recent MS therapy: _____ (MM/YY) ____/____ to ____/____

Concurrent medications: _____

Drug and non-drug allergies: _____ ☐ No known drug allergies (NKDA)

7 PRESCRIPTION(S) AND PRESCRIBER AUTHORIZATION† (Complete all parts that apply)

Initiation and Maintenance Rx:

Preferred Specialty Pharmacy: _____
Provide specialty pharmacy name

(!) **Initiation Rx:**

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

Days 1-4: ZEPOSIA® (ozanimod) 0.23 mg capsules by mouth once daily
Days 5-7: ZEPOSIA® (ozanimod) 0.46 mg capsules by mouth once daily
Day 8 and thereafter: ZEPOSIA® (ozanimod) 0.92 mg capsules by mouth once daily

Check one:

For new patients:

☐ Dispense Starter Kit‡ 7-day Starter Pack, followed by 30-day supply, 0 refills

For patients who are restarting:

☐ Dispense 7-day Titration Pack only, 0 refills

‡Starter Kit Rx is only for on-label patients who will not receive a 37-day sample from their prescriber.

Starter Kit or Titration Pack should be sent to:

☐ Prescriber address (see above)

If assessments are completed§:

☐ Patient address (see page 3) ☐ Alternate patient address (provide below)

Address _____ **City** _____

State _____ **ZIP** _____ **Phone** _____

§Assessments must be complete and confirmed by provider to ship Starter Kit or Titration Pack directly to patient.

(!) **Maintenance Rx (check one):**

ZEPOSIA® (ozanimod) 0.92 mg capsules by mouth once daily:

☐ Dispense 30-day supply followed by 11 refills or _____ refills

☐ Dispense 90-day supply followed by 3 refills or _____ refills

Additional notes: _____

Bridge Supply Rx‖ (optional for commercially insured patients):

Days 1-4: ZEPOSIA® (ozanimod) 0.23 mg capsules by mouth once daily
Days 5-7: ZEPOSIA® (ozanimod) 0.46 mg capsules by mouth once daily
Day 8 and thereafter: ZEPOSIA® (ozanimod) 0.92 mg capsules by mouth once daily

Check applicable box(es):

☐ Dispense Starter Kit‡ 7-day Starter Pack, followed by 30-day supply, 0 refills.

☐ Dispense 30-day supply followed by up to 11 refills

For patients who are restarting:

☐ Dispense 7-day Titration Pack only, 0 refills.

‡Starter Kit Rx is only for on-label patients who will not receive a 37-day sample from their prescriber.

‖Bridge Supply Rx is available at no cost for eligible commercially insured, on-label diagnosed patients if there is a delay of more than 10 business days in determining whether commercial prescription coverage is available, and is not contingent on any purchase requirement. Bridge Supply Rx is not available to patients who have prescription insurance coverage through Medicare, Medicaid, or any other federal or state program, or MA or MI residents, and is available for no more than 6 months (180 days) to patients in 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. Up to 12 additional refills may be provided if needed. Offer is not health insurance, and may be modified or discontinued at any time without notice. Other limitations may apply.

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 _____ X _____

Prescriber Signature (Dispense as Written) **Prescriber Signature (Substitutions Allowed)**

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