Bristol Myers Squibb patientconnect

Instructions

If you are enrolled in Medicare Part D, a Medicare Advantage prescription drug plan, or any other federal or state healthcare program, this letter serves as formal notification to your plan that you have purchased a BMS medicine outside of your plan benefit using the discount offered through Bristol Myers Squibb (BMS) Patient Connect.

Submission Instructions:

1. Review, sign, and mail the letter on Page 2 to your plan at the address provided on your plan documents.
2. Alternatively, you may fax or email the letter if your plan allows these options.
3. Keep a copy of this letter for your records.
4. Contact your plan's customer service if you have any questions about submission.

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Health Plan Notification Letter

Please review, sign, and submit this letter to your state or federal healthcare plan as instructed on Page 1.

To whom it may concern:

I am writing to inform you that my healthcare provider has prescribed me:

☑ Sotyktu

I have chosen to purchase this product outside of my plan benefit using the discount offered through Bristol Myers Squibb (BMS) Patient Connect.

Under the Terms and Conditions of BMS Patient Connect, I have agreed to the following:

- I will not seek reimbursement from my government insurance program for my out-of-pocket costs;
- I will not count the cost of my prescription toward my deductible or true out-of-pocket cost;
- I will purchase all prescriptions for my BMS Medicine during the calendar year using the BMS Patient Connect Program and not seek coverage for the BMS Medicine from any government insurance program at any time during this calendar year, even if my benefits change; and
- I will notify my government insurance program that my BMS Medicine has been purchased outside of my prescription plan by sending this BMS-provided letter.

If you have questions about this medication or BMS Patient Connect, please contact BMS Patient Connect at 866-526-7107, Monday through Friday, 9 AM – 8 PM EST.

Sincerely,

_____ _____

Name Date

_____ _____

Date of Birth Prescription Plan

_____

Prescription Plan Membership ID Number