PATIENT AUTHORIZATION AND AGREEMENT (continued)

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 1-855-961-0474 or complete the online form at www.bms.com/dpo/us/request.

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 from BMS, I agree to comply with the Program rules on my enrollment form and I will not get reimbursed for the assistance I receive from anyone else, including from an insurance program, another charity, or from 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 1-800-ORENCIA (1-800-673-6242) if my insurance or treatment changes in any way. If I have Medicare Part D, I will also not count on 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.

I Agree To Enroll In On Call Access Assistance

Patient Name:

Patient Signature: Date:

If signed by a personal representative, please print name of personal representative:

If signed by personal representative, please explain authority to act on behalf of the patient:

Power of Attorney documentation is required if someone other than the patient signs.
"You may fax the documents to 1-866-268-5385 or call 1-800-673-6242 for further assistance."

Patient Date of Birth: ZIP:

Preferred E-mail Address:

ORENCIA® On Call Patient Education & Resources

ORENCIA® On Call Patient Education and Resources is designed to provide patients with information and services related to my disease, ORENCIA refill reminders, surveys, and other information and alerts. By signing below, I agree to enroll in On Call Patient Education and Resources. BMS may contact me via mail, text/SMS, telephone, in electronic format or otherwise. BMS may also contact me about additional information, market research, clinical trials, and other offers that BMS believes may be of interest to me. My personal information may be used by and shared with BMS, the third parties it works with, and its authorized agents, subsidiaries, and assignees (collectively "BMS") to provide the services as well as for other purposes including improving or developing other communications and services, internal business purposes, including analytics. Information collected as part of this support program will be governed by the BMS privacy policy available on bms.com, which may change from time to time and I should check the website for the most recent version. I can stop future marketing communications and use of my information by calling 1-800-ORENCIA (1-800-673-6242).

☐ I agree to the Terms and Conditions (https://www.orencia.com/text-message-terms-conditions) of this Mobile Program and Privacy Policy (https://www.bms.com/privacy-policy.html). I consent to receive autodialed text messages on behalf of Bristol Myers Squibb. I understand that I will receive no more than 3 messages a month during the course of this program. Consent is not a condition of purchase or use of any Bristol Myers Squibb product. The Program is valid with most major U.S. carriers. I understand that message and data rates may apply. I understand that I can opt-out at any time by texting STOP to [42247]. I agree to receive one final text confirming my opt-out request.

I Agree To Enroll in On Call Patient Education and Resources

Patient Name:

Patient Signature: Date:

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

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