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:	Gender Male/Female:	Phone number:	E-Mail Address:
Number of people in household:		Is patient a U.S. Citizen or legal resident alien? ☐ YES	☐ NO
Contact Name:			

PATIENT FINANCIAL INFORMATION

Annual Gross Household Income	Patient/Spouse	Amount		Patient/Spouse	Amount
Salary Wages/Self-Employment (before deductions)			IRA or 401K Distributions		
Unemployment Compensation/Workers Compensation			Interest/Dividends/Royalties		
SS – Social Security Retirement/Survivor			General Relief/Public Assistance (i.e., TANF)		
SSDI – Social Security Disability Income			Alimony/Child Support		
SSI – Supplemental Security Income			Educational Grants/Scholarships		
Disability Payments (from Employer)			Other, please explain:		
Pension/Retirement/Military Pension/Veterans Benefits					

Total Annual income before taxes: Including all Income, Wages, Social Security, Pension, Disability, Interest Earned or Savings, etc. **Total** $

INSURANCE INFORMATION

Private Insurance	Yes ☐ No ☑	Medicare A	Yes ☐ No ☑
Prescription Drug Coverage	Yes ☐ No ☑	Medicare B	Yes ☐ No ☑
Medicaid (Please attach copy of Medicaid card)	Yes ☐ No ☑	Medicare D	Yes ☐ No ☑
Have you applied for Medicaid in the past and been denied? (If so, please attach copy of Medicaid denial.)	Yes ☐ No ☑	VA or Military Benefits	Yes ☐ No ☑

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:
DEA# (If not available, please provide copy of State License): State License #:		E-Mail Address:
Shipping Address 1: (Drugs cannot be shipped to the patient or P.O. Box)	550 S. VERMONT AVE ROOM 903	
Shipping Address 2:		
City: LOS ANGELES	State: CA	Zip Code: 90020
Contact Name:	Phone Number: ( ) (213) 351-7764	Fax: ( ) (213) 738-3116
Drug Name: Abilify	Days Supply: 90	Diagnosis Code:

REQUESTED MEDICATION (PLEASE CHOOSE):	☐ ABILIFY 5 mg ____ Quantity / Day	☐ ABILIFY 10 mg ____ Quantity / Day	☐ ABILIFY 15 mg ____ Quantity / Day	☐ ABILIFY 20 mg ____ Quantity / Day	☐ ABILIFY 30 mg ____ Quantity / Day

Is this a change in dose schedule for an existing BMSPAF member? YES 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: _____

Clear entire form

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

CLIENT:

Name of Client/Previous Names | Birth Date | MIS Number

Street Address | City, State, Zip

AUTHORIZES:

Name of Agency

Street Address

City, State, Zip Code

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:

BRISTOL - MYERS SQUIBB
Name of Health Care Provider/Plan/Other

P.O. BOX 8309
Street Address

SOMERVILLE, NJ 08876
City, State, Zip Code

INFORMATION TO BE RELEASED:

- ☐ Assessment/Evaluation
- ☐ Laboratory Results
- ☐ Entire Record (Justify)
- ☒ Other (Specify): PATIENT FINANCIAL INFORMATION
- ☐ Results of Psychological Tests
- ☒ Medication History/ Current Medications
- ☐ Diagnosis
- ☐ Treatment

PURPOSE OF DISCLOSURE: (Check applicable categories)

- ☒ Client's Request
- ☐ Other (Specify):

Will the agency receive any benefits for the disclosure of this information? ☐ Yes ☒ No

I understand that PHI used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless such use or disclosure is specifically required or permitted by law.

EXPIRATION DATE: This authorization is valid until the following date: ____/____/____
Month Day Year

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:

Right to Receive a Copy of This Authorization - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to Revoke This Authorization - I understand that I have the right to revoke this Authorization at any time by telling DMH in writing. I may use the Revocation of Authorization at the bottom of this form, mail or deliver the revocation to:

Contact person	Agency Name
Street Address	City, State, Zip

I also understand that a revocation will not affect the ability of DMH or any health care provider to use or disclose the health information for reasons related to the prior reliance on this Authorization.

Conditions. I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, DMH may condition the provision of research-related treatment on obtaining an authorization to use or disclose protected health information created for that research-related treatment. (In other words, if this authorization is related to research that includes treatment, you will not receive that treatment unless this authorization form is signed.)

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____ _____

Signature of Client / Personal Representative Date

If signed by other than the client, state relationship and authority to do so: _____

REVOCATION OF AUTHORIZATION

SIGNATURE OF CLIENT/LEGAL REP: _____

If signed by other than client, state relationship and authority to do so: _____

DATE: _____/_____/_____
Month Day Year

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
OFFICE OF THE MEDICAL DIRECTOR
Indigent Medications Program

Date:

TO: BRISTOL - MYERS SQUIBB (Pharmaceutical Company)

FROM: _____ _____
(Doctor's Name) (Doctor's Signature)

_____
(Name of Clinic)
County of Los Angeles/Department of Mental Health

SUBJECT: BENEFITS STATUS LETTER

_____ (Client's Name)

This client is unable to produce documentation as to the status of his/her Medicaid application. However, the County of Los Angeles has been able to determine, through our access to the State of California information system, the following:

☒ The client is being considered as an applicant for Medicaid/SSI/SSDI. Application is in the process of being developed. (Application and history establishment and/or documentation of 12 consecutive months of psychiatric treatment are in the process of being developed.)

☐ The client has applied for Medicaid/ SSI/ SSDI. _____ (Date) Results are pending.

☐ The client has been denied Medicaid. _____ (Date)

☐ The client has been denied SSI/SSDI. _____ (Date)

Comments _____

_____

There will be continued efforts to assist this client to obtain prescription and other benefits to which he/she is entitled, through the LAC – DMH benefits establishment programs. Please consider this client for enrollment in your Patient Assistance Program. Thank you.

BRISTOL – MYERS SQUIBB PATIENT ASSISTANCE FOUNDATION, INC.
P.O. Box 1058
Somerville, NJ 08876
Phone: (800) 736-0003
Fax: (866) 310-7550

Priority Facsimile Transmittal

To: Doreen or Keith **Fax:** 1-866-310-7550

From: **Date:**

Re: Abilify Patient Assistance Foundation **Pages:**

CC:

☑ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

Priority Facsimile Transmittal

DEPARTMENT OF MENTAL HEALTH

DMH FAX COVER FOR TRANSMITTING PHI

FAX DETAILS

Date Transmitted: _____ Time Transmitted: _____

Number of Pages (including cover sheet): _____

Intended Recipient: DMH PHARMACY SERVICES

TO	FROM
Name: PHARMACY SERVICES	Name: _____
Facility: LAC - DMH	Facility: _____
Address: 550 S. VERMONT, ROOM 903, LA, CA, 90020	Address: _____
Telephone #: 1-213-738-2060	Telephone #: _____
Fax #: 1-213-738-3116	Fax #: _____

Documents being faxed:

- ☐ Clinical Records
- ☐ Other: PATIENT ASSISTANCE PROGRAM APPLICATIONS

CONFIDENTIALITY STATEMENT

This facsimile transmission may contain information that is privileged and confidential and is intended only for the use of the person or entity named above. If you are neither the intended recipient nor the employee or agent of the intended recipient responsible for the delivery of this information, you are hereby notified that the disclosure, copying, use or distribution of this information is strictly prohibited. In addition, there are federal civil and criminal penalties for the misuse or inappropriate disclosure of confidential patient information. If you have received the transmission in error, please notify contact person immediately by telephone to arrange for the return of the transmitted documents to us or to verify their destruction.

VERIFICATION OF TRANSMISSION OF PHI

Please contact _____ at _____ to verify receipt of this Fax or to report problems with the transmission.

I verify the receiver of this Fax has confirmed its transmission:

Name: _____ Date: _____ Time: _____

DMH Treatment Team Representative