SOTYKTU™ (deucravacitinib) 6 mg tablets

SOTYKTU 360 SUPPORT ACCESS & REIMBURSEMENT GUIDE

SIMPLY COMMITTED TO PATIENT SUPPORT

SOTYKTU 360 SUPPORT Your circle of support

1787-US-2200173 09/22

Please see Important Safety Information on slides 3-5 and full Prescribing Information, including Medication Guide, available at the end of this presentation.

SOTYKTU 360 SUPPORT Overview

Simply committed to patient support

START

Enroll Patients With the Start Form

See slide 7 for additional details on how to complete and submit the SOTYKTU Start Form.

SOTYKTU Free Trial Offer*

Patients new to SOTYKTU may be eligible to receive a **30-day** free trial in the mail.* See slide 13 for more details.

Benefits Investigation

SOTYKTU 360 SUPPORT can help conduct a benefits investigation and share the results with your office and the patient. See slide 15 for more details.

Prior Authorization (PA) & Appeals Support

If a PA or appeal is needed, SOTYKTU 360 SUPPORT can communicate requirements to your office and can check the status once submitted. See slide 17 for more details

Additional Resources

See slide 26 for information for your patients.

STAY

SOTYKTU Bridge Program*

Eligible, commercially insured patients may access SOTYKTU for up to 3 years if there is a delay or denial during the insurance coverage determination process. See slide 21 for more details.

SAVE

SOTYKTU Co-Pay Assistance Program*

Eligible, commercially insured patients may pay as little as $0 every month for SOTYKTU with the SOTYKTU Co-Pay Assistance Card. See slide 23 for more details.

Third Party Referrals

SOTYKTU 360 SUPPORT may be able to help identify possible independent financial support options for patients with affordability concerns. See slide 24 for more details.

*Please click here to review Program Terms and Conditions.

The accurate completion of reimbursement or coverage-related documentation is the responsibility of the healthcare provider and patient. Bristol-Myers Squibb and its agents make no guarantee regarding reimbursement for any service or item.

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SOTYKTU 360 SUPPORT (deucravacitinib) 6 mg tablets

SOTYKU (deucravacitinib) Indication and Important Safety Information

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INDICATION

SOTYKTU™ (deucravacitinib) is indicated for the treatment of moderate-to-severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy.

Limitations of Use:

SOTYKTU is not recommended for use in combination with other potent immunosuppressants.

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

SOTYKTU is contraindicated in patients with a history of hypersensitivity reaction to deucravacitinib or to any of the excipients in SOTYKTU.

WARNINGS AND PRECAUTIONS

Hypersensitivity: Hypersensitivity reactions such as angioedema have been reported. If a clinically significant hypersensitivity reaction occurs, institute appropriate therapy and discontinue SOTYKTU.

Infections: SOTYKTU may increase the risk of infections. Serious infections have been reported in patients with psoriasis who received SOTYKTU. The most common serious infections reported with SOTYKTU included pneumonia and COVID-19. Avoid use of SOTYKTU in patients with an active or serious infection. Consider the risks and benefits of treatment prior to initiating SOTYKTU in patients:

- with chronic or recurrent infection
- who have been exposed to tuberculosis
- with a history of a serious or an opportunistic infection
- with underlying conditions that may predispose them to infection.

Closely monitor patients for the development of signs and symptoms of infection during and after treatment. A patient who develops a new infection during treatment should undergo prompt and complete diagnostic testing, have appropriate antimicrobial therapy initiated and be closely monitored. Interrupt SOTYKTU if a patient develops a serious infection. Do not resume SOTYKTU until the infection resolves or is adequately treated.

Continued on next slide

Please see Important Safety Information on slides 3-5 and full Prescribing Information, including Medication Guide, available at the end of this presentation.

SOTYKU (deucravacitinib) Indication and Important Safety Information (cont'd)

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WARNINGS AND PRECAUTIONS (cont'd)

Viral Reactivation

Herpes virus reactivation (e.g., herpes zoster, herpes simplex) was reported in clinical trials with SOTYKTU. Through Week 16, herpes simplex infections were reported in 17 patients (6.8 per 100 patient-years) treated with SOTYKTU, and 1 patient (0.8 per 100 patient-years) treated with placebo. Multidermatomal herpes zoster was reported in an immunocompetent patient. During PSO-1, PSO-2, and the open-label extension trial, the majority of patients who reported events of herpes zoster while receiving SOTYKTU were under 50 years of age. The impact of SOTYKTU on chronic viral hepatitis reactivation is unknown.

Consider viral hepatitis screening and monitoring for reactivation in accordance with clinical guidelines before starting and during therapy with SOTYKTU. If signs of reactivation occur, consult a hepatitis specialist. SOTYKTU is not recommended for use in patients with active hepatitis B or hepatitis C.

Tuberculosis (TB): In clinical trials, of 4 patients with latent TB who were treated with SOTYKTU and received appropriate TB prophylaxis, no patients developed active TB (during the mean follow-up of 34 weeks). One patient, who did not have latent TB, developed active TB after receiving 54 weeks of SOTYKTU. Evaluate patients for latent and active TB infection prior to initiating treatment with SOTYKTU. Do not administer SOTYKTU to patients with active TB. Initiate treatment of latent TB prior to administering SOTYKTU. Consider anti-TB therapy prior to initiation of SOTYKTU in patients with a past history of latent or active TB in whom an adequate course of treatment cannot be confirmed. Monitor patients for signs and symptoms of active TB during treatment.

Malignancy including Lymphomas: Malignancies, including lymphomas, were observed in clinical trials with SOTYKTU. Consider the benefits and risks for the individual patient prior to initiating or continuing therapy with SOTYKTU, particularly in patients with a known malignancy (other than a successfully treated non-melanoma skin cancer) and patients who develop a malignancy when on treatment with SOTYKTU.

Rhabdomyolysis and Elevated CPK: Treatment with SOTYKTU was associated with an increased incidence of asymptomatic creatine phosphokinase (CPK) elevation and rhabdomyolysis compared to placebo. Discontinue SOTYKTU if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Instruct patients to promptly report unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Laboratory Abnormalities: Treatment with SOTYKTU was associated with increases in triglyceride levels. Periodically evaluate serum triglycerides according to clinical guidelines during treatment. SOTYKTU treatment was associated with an increase in the incidence of liver enzyme elevation compared to placebo. Evaluate liver enzymes at baseline and thereafter in patients with known or suspected liver disease according to routine management. If treatment-related increases in liver enzymes occur and drug-induced liver injury is suspected, interrupt SOTYKTU until a diagnosis of liver injury is excluded.

Continued on next slide

Please see Important Safety Information on slides 3-5 and full Prescribing Information, including Medication Guide, available at the end of this presentation.

SOTYKU (deucravacitinib) Indication and Important Safety Information (cont'd)

RETURN TO HOME

WARNINGS AND PRECAUTIONS (cont'd)

Immunizations: Prior to initiating therapy with SOTYKTU, consider completion of all age-appropriate immunizations according to current immunization guidelines including prophylactic herpes zoster vaccination. Avoid use of live vaccines in patients treated with SOTYKTU. The response to live or non-live vaccines has not been evaluated.

Potential Risks Related to JAK Inhibition: It is not known whether tyrosine kinase 2 (TYK2) inhibition may be associated with the observed or potential adverse reactions of Janus Kinase (JAK) inhibition. In a large, randomized, postmarketing safety trial of a JAK inhibitor in rheumatoid arthritis (RA), patients 50 years of age and older with at least one cardiovascular risk factor, higher rates of all-cause mortality, including sudden cardiovascular death, major adverse cardiovascular events, overall thrombosis, deep venous thrombosis, pulmonary embolism, and malignancies (excluding non-melanoma skin cancer) were observed in patients treated with the JAK inhibitor compared to those treated with TNF blockers. SOTYKTU is not approved for use in RA.

ADVERSE REACTIONS

Most common adverse reactions (≥1% of patients on SOTYKTU and more frequently than with placebo) include upper respiratory infections, blood creatine phosphokinase increased, herpes simplex, mouth ulcers, folliculitis and acne.

SPECIFIC POPULATIONS

Pregnancy: Available data from case reports on SOTYKTU use during pregnancy are insufficient to evaluate a drug-associated risk of major birth defects, miscarriage, or adverse maternal or fetal outcomes. Report pregnancies to the Bristol-Myers Squibb Company's Adverse Event reporting line at 1-800-721-5072.

Lactation: There are no data on the presence of SOTYKTU in human milk, the effects on the breastfed infant, or the effects on milk production. SOTYKTU is present in rat milk. When a drug is present in animal milk, it is likely that the drug will be present in human milk. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for SOTYKTU and any potential adverse effects on the breastfed infant from SOTYKTU or from the underlying maternal condition.

Hepatic Impairment: SOTYKTU is not recommended for use in patients with severe hepatic impairment.

SOTYKTU is available in 6 mg tablets.

Please see U.S. Full Prescribing Information, including Medication Guide, for SOTYKTU.

Please see Important Safety Information on slides 3-5 and full Prescribing Information, including Medication Guide, available at the end of this presentation.

It begins with your SOTYKTU 360 SUPPORT team

Your SOTYKTU 360 SUPPORT team:

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DEDICATED SOTYKTU Support Coordinators*

- Assist with benefits investigations and prior authorizations (PAs)
- Explain insurance coverage and pharmacy benefits
- Help eligible patients access SOTYKTU if it isn't initially covered by commercial or private insurance via the SOTYKTU Bridge Program†
- Enroll eligible patients into the SOTYKTU Co-Pay Assistance Program†
- Identify and coordinate with a specialty pharmacy to arrange shipments
- Provide patients with information about other available resources

Available to you and your patients from 8 AM to 8 PM ET, Monday through Friday, at **1-888-SOTYKTU (768-9588)**.

Access and Reimbursement Managers (ARMs)

- Educate on SOTYKTU 360 SUPPORT after a prescribing decision has been made
- Assist with patient access challenges
- Provide timely responses to access and reimbursement questions
- Share knowledge regarding local access landscape

Contact your ARM for general access or reimbursement support questions and to schedule an office visit.

*SOTYKTU Support Coordinators can provide general information about SOTYKTU but cannot provide medical advice.

†Please click here to review Program Terms and Conditions.

The accurate completion of reimbursement or coverage-related documentation is the responsibility of the healthcare provider and patient. Bristol-Myers Squibb and its agents make no guarantee regarding reimbursement for any service or item.

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Enrolling your patients in SOTYKTU 360 SUPPORT

Get started in 3 steps. To enroll your patient, assist them in completing the Start Form

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STEP 1 SELECT

Complete the Start Form and, if applicable, **select** the following options:

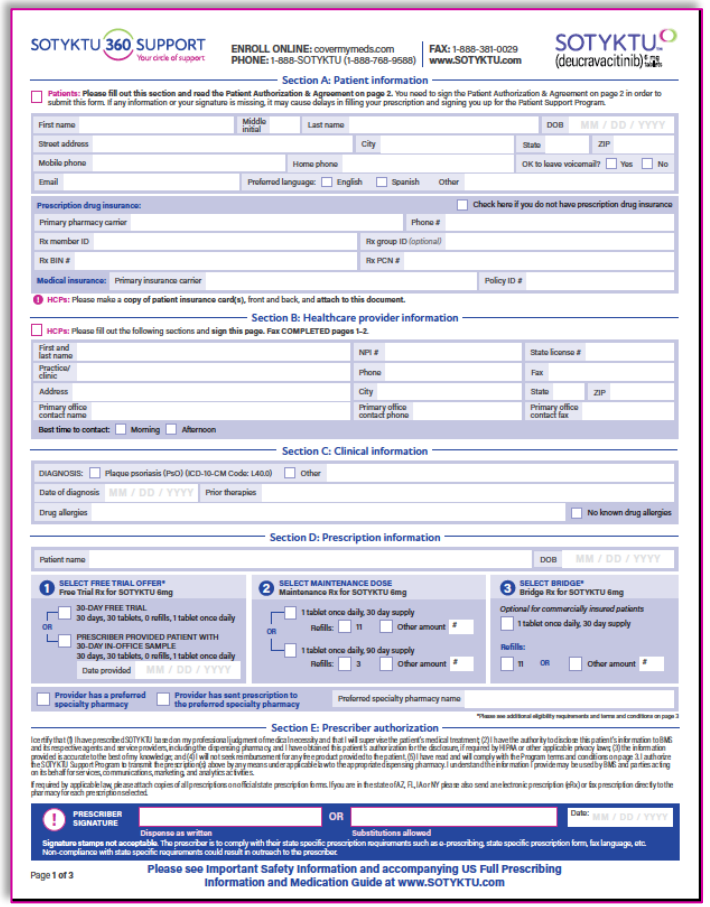
- SOTYKTU Free Trial Offer*
- Maintenance Dose
- SOTYKTU Bridge Program*†

STEP 2 SIGN

- After you sign, ensure that patients **sign** the Patient Authorization

STEP 3 SUBMIT

- Fax the fully completed and signed Start Form to **1-888-381-0029** or submit through CoverMyMeds.com. To get started, create an account on CoverMyMeds.com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FAX: 1-888-381-0029
www.SOTYKTU.com

SOTYKTU® (deucravacitinib) 6 mg tablets

Section A: Patient information

Patients: Please fill out this section and read the Patient Authorization & Agreement on page 2. You need to sign the Patient Authorization & Agreement on page 2 in order to submit this form. 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 MM / DD / YYYY
Street address | City | State | ZIP
Mobile phone | Home phone | OK to leave voicemail? Yes No
Email | Preferred language: English Spanish Other

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 #

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 this page. Fax COMPLETED pages 1–2.

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 MM / DD / YYYY | Prior therapies
Drug allergies | No known drug allergies

Section D: Prescription information

Patient name | DOB MM / DD / YYYY

1 SELECT FREE TRIAL OFFER* Free Trial Rx for SOTYKTU 6mg
30-DAY FREE TRIAL 30 days, 30 tablets, 0 refills, 1 tablet once daily
OR
PRESCRIBER PROVIDED PATIENT WITH 30-DAY IN-OFFICE SAMPLE 30 days, 30 tablets, 0 refills, 1 tablet once daily
Date provided MM / DD / YYYY

2 SELECT MAINTENANCE DOSE Maintenance Rx for SOTYKTU 6mg
1 tablet once daily, 30 day supply
Refills: 11 Other amount #
OR
1 tablet once daily, 90 day supply
Refills: 3 Other amount #

3 SELECT BRIDGE* Bridge Rx for SOTYKTU 6mg
Optional for commercially insured patients
1 tablet 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 3

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; and (4) I will not seek reimbursement for any the product provided to the patient. (5) I have read and will comply with the Program terms and conditions on page 3. I authorize the SOTYKTU Support Program to transmit the prescription(s) above by any means used or applicable by me 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: MM / DD / YYYY
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.

Page 1 of 3

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

NOW IT'S OUR TURN

After submitting the Start Form, let your patients know that their SOTYKTU Support Coordinator will be in touch to help patients access prescribed medication.

*Please click here to review Program Terms and Conditions.

†For patients eligible for the SOTYKTU Bridge Program, submit a Prior Authorization (PA) to the patient's payer as soon as possible. If the PA is denied, submit an appeal, exception, and/or Letter of Medical Necessity within 90 days or per payer requirements.
The accurate completion of reimbursement or coverage-related documentation is the responsibility of the healthcare provider and patient. Bristol-Myers Squibb and its agents make no guarantee regarding reimbursement for any service or item.

Please see Important Safety Information on slides 3-5 and full Prescribing Information, including Medication Guide, available at the end of this presentation.

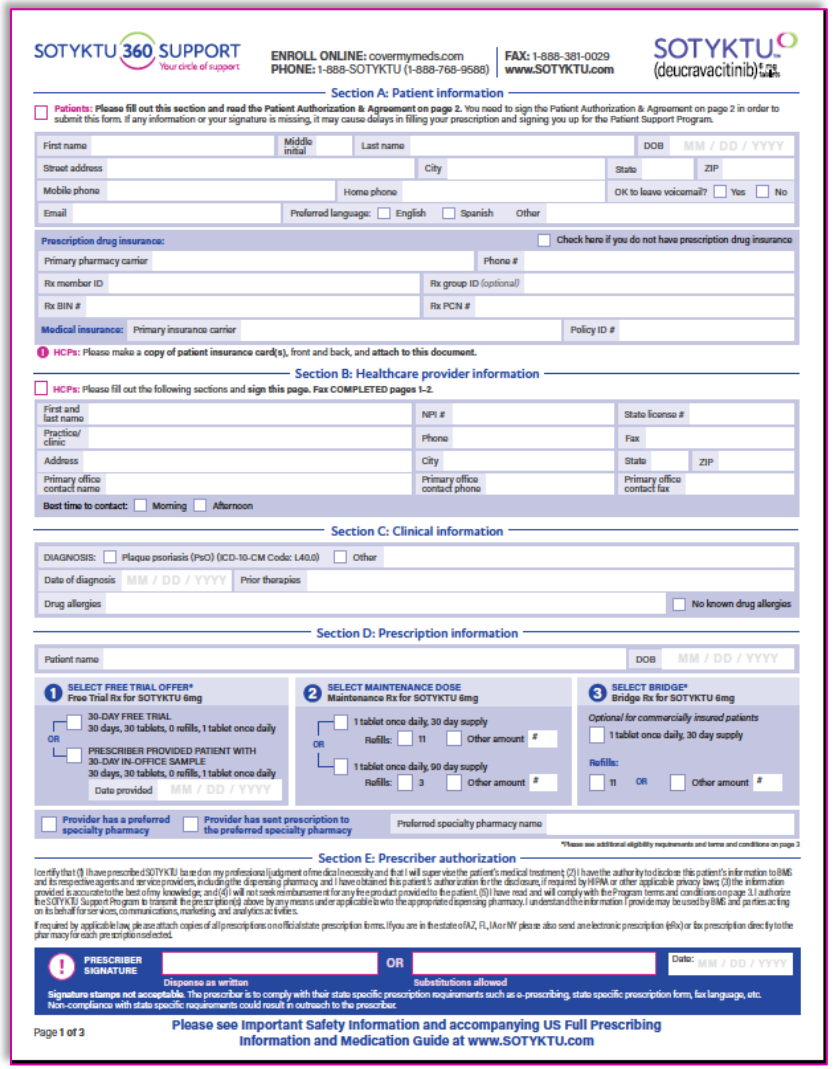
Steps to complete the SOTYKTU Start Form

RETURN TO HOME

FIRST | Complete Patient Information in Section A on page 1 of the form

SECOND | Complete the HCP information in Sections B-E on page 1 of the form

THIRD | Have the patient sign and date the bottom of the Patient Authorization Agreement (PAA) on page 2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SOTYKTU (deucravacitinib) 6 mg tablets

Section A: Patient information

Patients: Please fill out this section and read the Patient Authorization & Agreement on page 2. You need to sign the Patient Authorization & Agreement on page 2 in order to submit this form. 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 MM / DD / YYYY
Street address | City | State | ZIP
Mobile phone | Home phone | OK to leave voicemail? Yes No
Email | Preferred language: English Spanish Other

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 #

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 this page. Fax COMPLETED pages 1–2.

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 MM / DD / YYYY | Prior therapies
Drug allergies | No known drug allergies

Section D: Prescription information

Patient name | DOB MM / DD / YYYY

1 SELECT FREE TRIAL OFFER* Free Trial Rx for SOTYKTU 6mg
30-DAY FREE TRIAL
30 days, 30 tablets, 0 refills, 1 tablet once daily
OR
PRESCRIBER PROVIDED PATIENT WITH 30-DAY IN-OFFICE SAMPLE
30 days, 30 tablets, 0 refills, 1 tablet once daily
Date provided MM / DD / YYYY

2 SELECT MAINTENANCE DOSE Maintenance Rx for SOTYKTU 6mg
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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 3

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; and (4) I will not seek reimbursement for any free product provided to the patient. (5) I have read and will comply with the Program terms and conditions on page 3. 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: MM / DD / YYYY
Dispense as written | Substitutions allowed
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Page 1 of 3

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

All sections marked with a pink exclamation point must be filled out for the form to be processed.

NOTE: Once you have completed these 3 sections, you have fully completed the Start Form and are ready to submit.

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Completing the SOTYKTU Start Form

RETURN TO HOME

PATIENT INFORMATION

Fill Out the Start Form on Page 1, Section A

The Basics

As you fill out the form, be sure to include:

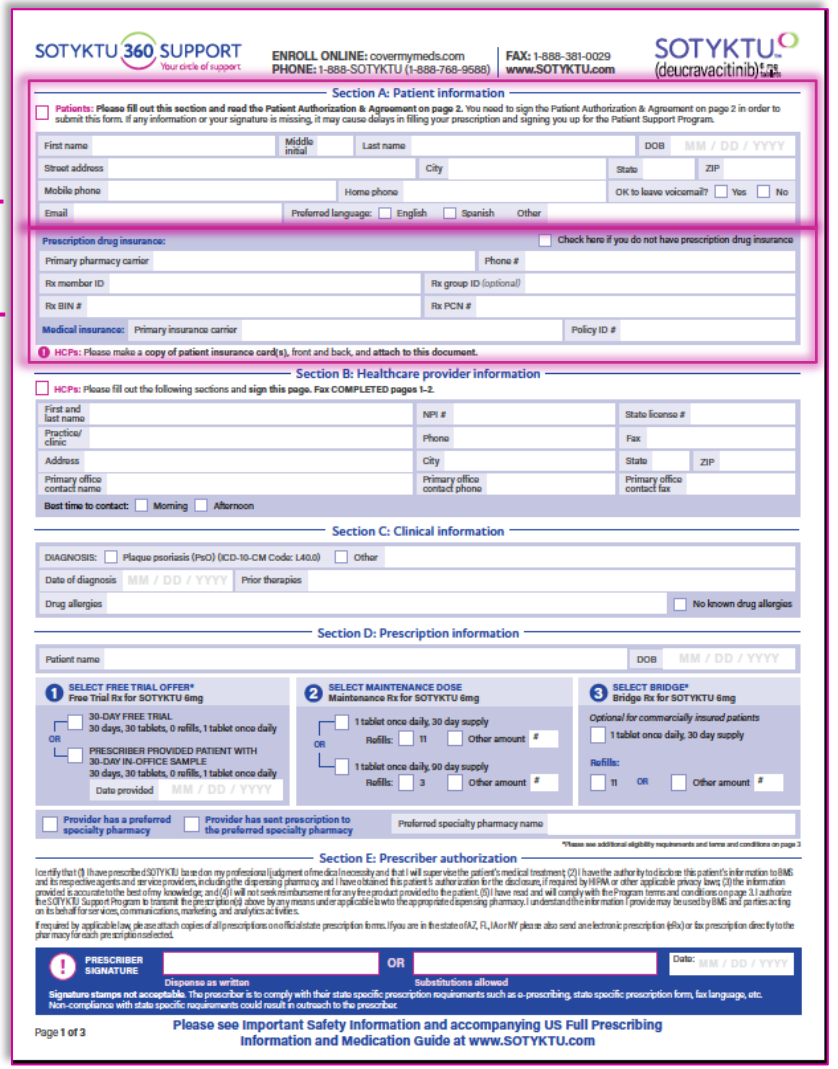
- **Name and date of birth:** The patient's full name and date of birth are required for processing
- **Phone number:** Mobile or home phone number is required to allow us to contact patients with additional questions or notifications
- **Email:** Patients can receive communications and important updates about product shipments through email

Prescription Drug Insurance

- **Insurance:** Filling in the right insurance carrier and policy number is required to determine whether the patient may be approved for SOTYKTU and covered for the cost of therapy

Important Note for You and Your Patients:

- **All patients should read:** Patient Authorization and Agreement (PAA) (page 2)



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Section A: Patient information

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Street address | City | State | ZIP
Mobile phone | Home phone | OK to leave voicemail? Yes No
Email | Preferred language: English Spanish Other

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 #

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

Section B: Healthcare provider information

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Address | City | State | ZIP
Primary office contact name | Primary office contact phone | Primary office contact fax
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Section C: Clinical information

DIAGNOSIS: Plaque psoriasis (PsO) (ICD-10-CM Code: L40.0) Other
Date of diagnosis MM / DD / YYYY | Prior therapies
Drug allergies | No known drug allergies

Section D: Prescription information

Patient name | DOB MM / DD / YYYY

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Page 1 of 3

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Completing the SOTYKTU Start Form (cont'd)

RETURN TO HOME

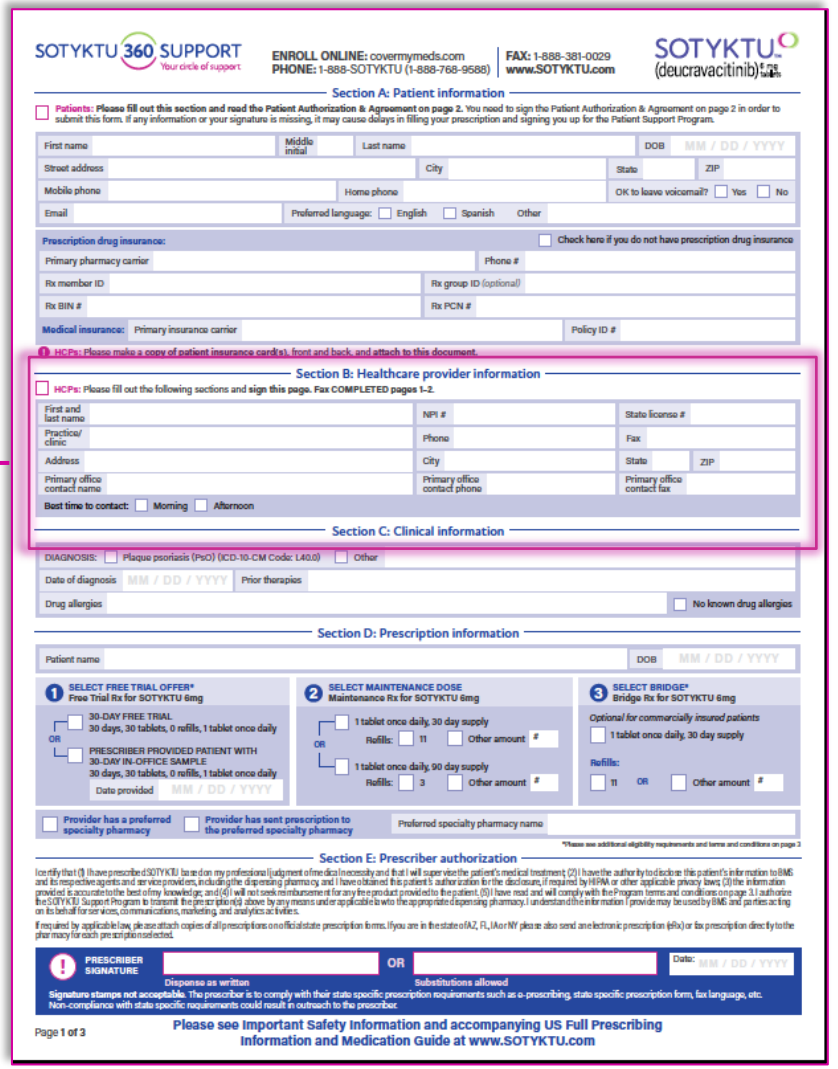
HCP INFORMATION

Fill Out the Start Form on Page 1, Sections B-E

Prescriber Information

As you fill out the form, be sure to include:

- **Your Name, address, and contact information:** Just as with the patient, it's required to have your full name and phone number so we can contact you directly as we process the Start Form; also, be sure to include the address of your office, your NPI number, and your State Medical License number



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Street address | City | State | ZIP
Mobile phone | Home phone | OK to leave voicemail? Yes No
Email | Preferred language: English Spanish Other

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 #

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

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HCPs: Please fill out the following sections and sign this page. Fax COMPLETED pages 1–2.

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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
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Drug allergies | No known drug allergies

Section D: Prescription information

Patient name | DOB MM / DD / YYYY

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PRESCRIBER PROVIDED PATIENT WITH 30-DAY IN-OFFICE SAMPLE
30 days, 30 tablets, 0 refills, 1 tablet once daily
Date provided MM / DD / YYYY

2 SELECT MAINTENANCE DOSE — Maintenance Rx for SOTYKTU 6mg
1 tablet once daily, 30 day supply
Refills: 11 Other amount #
OR
1 tablet once daily, 90 day supply
Refills: 3 Other amount #

3 SELECT BRIDGE* — Bridge Rx for SOTYKTU 6mg
Optional for commercially insured patients
1 tablet 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 3

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; and (4) I will not seek reimbursement for any free product provided to the patient. (5) I have read and will comply with the Program terms and conditions on page 3. 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 | Dispense as written | OR | Substitutions allowed | Date: MM / DD / YYYY

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.

Page 1 of 3

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

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Please see Important Safety Information on slides 3-5 and full Prescribing Information, including Medication Guide, available at the end of this presentation.

Completing the SOTYKTU Start Form (cont'd)

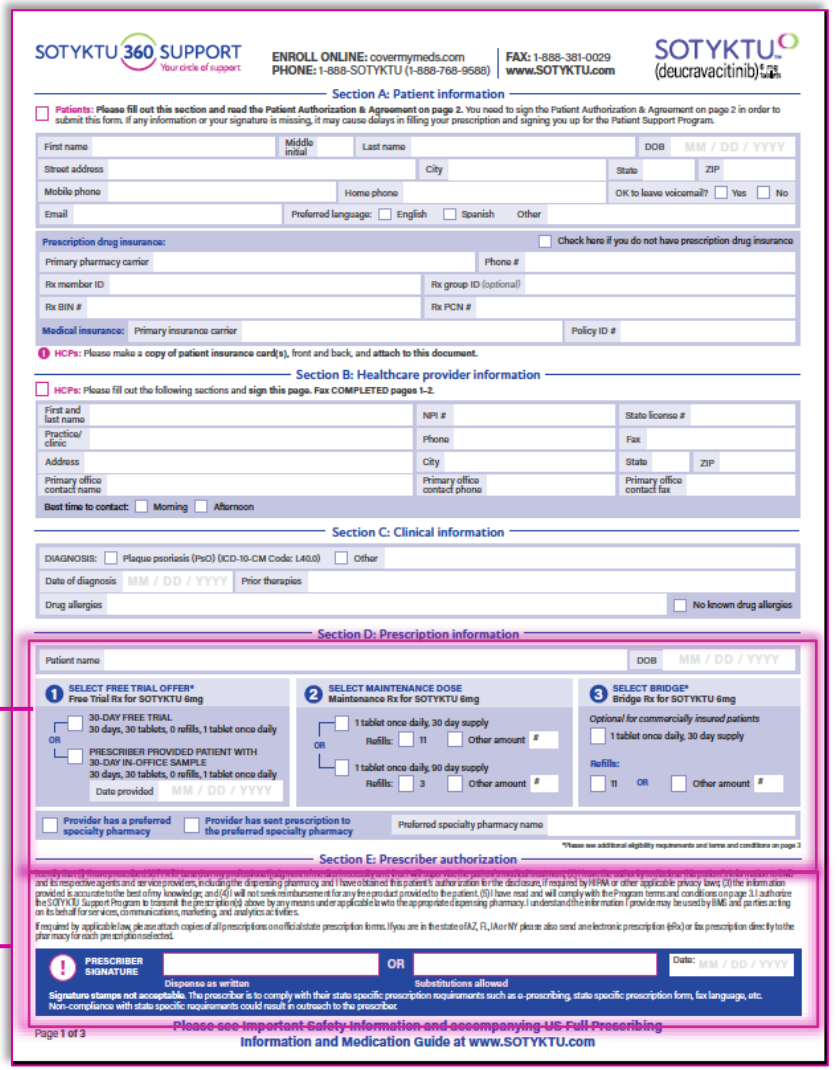
RETURN TO HOME

Treatment Information

- **Diagnosis:** It is required to identify the patient's diagnosis
- **SOTYKTU Free Trial Offer*:** The SOTYKTU Free Trial Offer for SOTYKTU includes a 30-day supply of SOTYKTU that is available at no cost to eligible patients through SOTYKTU 360 SUPPORT. See the SOTYKTU Free Trial Offer full terms and conditions on page 3 of the Start Form
- **Maintenance Dose:** 30-day and 90-day supplies of the SOTYKTU maintenance dose can be ordered using this form. Just check the appropriate box and indicate the number of refills you may want to prescribe. You may also indicate if there is a preferred Specialty Pharmacy to use
- **SOTYKTU Bridge Program*:** Patients experiencing a delay or denial with coverage may be eligible for the SOTYKTU Bridge Program. Eligible patients with commercial or private insurance may be able to receive SOTYKTU free of charge for up to 3 years while awaiting coverage. See the SOTYKTU Bridge Program full terms and conditions on page 3 of the Start Form

Prescriber Authorization

- **Signature:** Be sure to sign the form when you are finished. Your signature is required in order for the Start Form to be processed


SOTYKTU 360 SUPPORT
Your circle of support
ENROLL ONLINE: covermymeds.com
PHONE: 1-888-SOTYKTU (1-888-768-9588)
FAX: 1-888-381-0029
www.SOTYKTU.com
SOTYKTU (deucravacitinib) 6 mg tablets

Section A: Patient information
Patients: Please fill out this section and read the Patient Authorization & Agreement on page 2. You need to sign the Patient Authorization & Agreement on page 2 in order to submit this form. 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 MM / DD / YYYY
Street address | City | State | ZIP
Mobile phone | Home phone | OK to leave voicemail? Yes No
Email | Preferred language: English Spanish Other
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 #
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 this page. Fax COMPLETED pages 1–2.
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 MM / DD / YYYY | Prior therapies
Drug allergies | No known drug allergies

Section D: Prescription information
Patient name | DOB MM / DD / YYYY
1 SELECT FREE TRIAL OFFER* Free Trial Rx for SOTYKTU 6mg
30-DAY FREE TRIAL 30 days, 30 tablets, 0 refills, 1 tablet once daily
OR
PRESCRIBER PROVIDED PATIENT WITH 30-DAY IN-OFFICE SAMPLE 30 days, 30 tablets, 0 refills, 1 tablet once daily
Date provided MM / DD / YYYY
2 SELECT MAINTENANCE DOSE Maintenance Rx for SOTYKTU 6mg
1 tablet once daily, 30 day supply
Refills: 11 Other amount #
OR
1 tablet once daily, 90 day supply
Refills: 3 Other amount #
3 SELECT BRIDGE* Bridge Rx for SOTYKTU 6mg
Optional for commercially insured patients
1 tablet 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 3

Section E: Prescriber authorization
PRESCRIBER SIGNATURE
Dispense as written OR Substitutions allowed
Date: MM / DD / YYYY
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.
Page 1 of 3
Please see Important Safety Information and accompanying US Full Prescribing Information and Medication Guide at www.SOTYKTU.com

*Please click here to review Program Terms and Conditions.

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Completing the SOTYKTU Start Form (cont'd)

RETURN TO HOME

PATIENT SIGNATURE

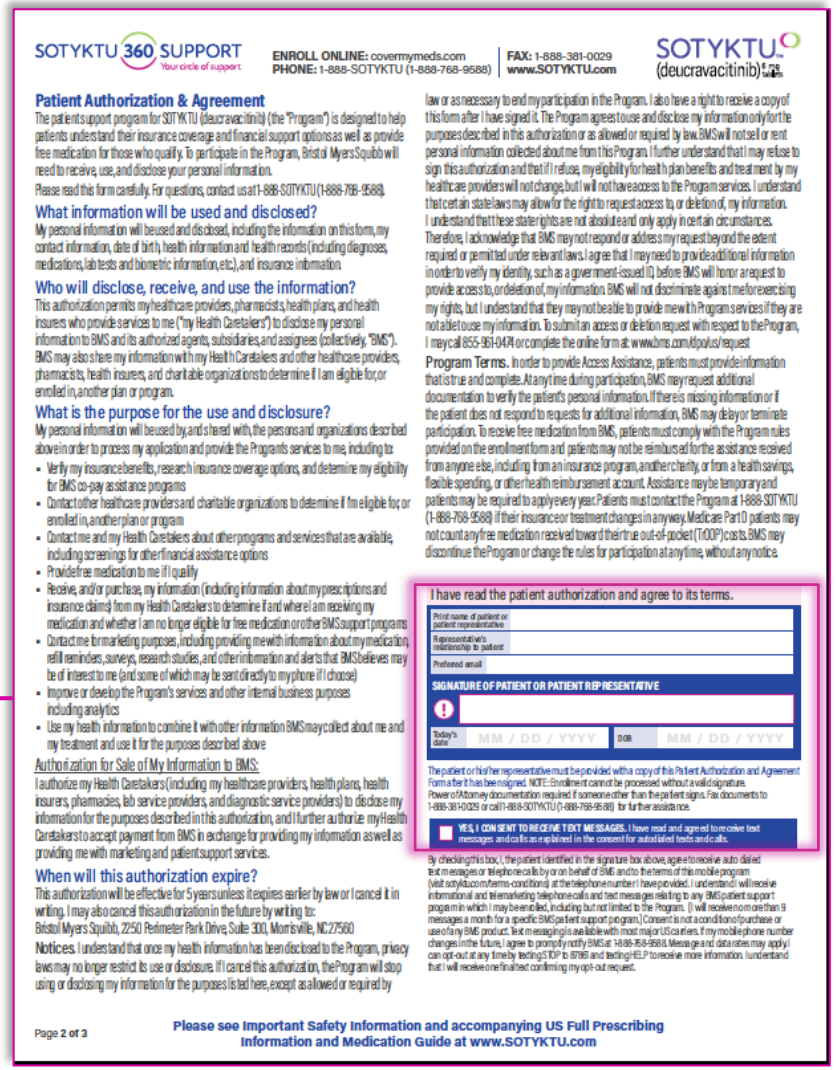
Obtain Signature and Date on Page 2

Patient Authorization

The patient's signature and date are required.

If patients prefer to fill out the form electronically, they can visit SOTYKTU.com/esign to provide an electronic signature.

Once the patient has signed the form, you should provide them with a **photocopy** of the signature page as well as page 3 with the program terms and conditions. Be sure to keep the **original** signature page for your office, as you will need it for your submission.



SOTYKTU 360 SUPPORT Your circle of support

ENROLL ONLINE: covermymeds.com
PHONE: 1-888-SOTYKTU (1-888-768-9588)
FAX: 1-888-381-0029
www.SOTYKTU.com

SOTYKTU (deucravacitinib) 6 mg tablets

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 855-951-0474 or complete the online form at: www.bms.com/dpo/us/request

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 MM / DD / YYYY DOB MM / DD / YYYY

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 autodialed 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. [I will receive no more than 9 messages a month for a specific BMS patient support program.] 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 87768 and texting HELP to receive more information. I understand that I will receive one final text confirming my opt-out request.

Page 2 of 3

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

Please see Important Safety Information on slides 3-5 and full Prescribing Information, including Medication Guide, available at the end of this presentation.

SOTYKTU Free Trial Offer

For eligible patients getting started on SOTYKTU

RETURN TO HOME

First-time eligible patients may receive a 30-day free trial in the mail*

Complete and submit the Start Form through CoverMyMeds.com or fax it to **1-888-381-0029** for the 30-day SOTYKTU Free Trial Offer

ELIGIBILITY REQUIREMENTS

To be eligible for the SOTYKTU Free Trial Offer for SOTYKTU (deucravacitinib)*:

- Patients must be new patients who have not previously received a sample or filled a prescription for SOTYKTU
- Patient must have a valid 30-day prescription for SOTYKTU for an on-label indication
- Patients are 18 years of age or older
- Patients are residents of the United States or a US Territory

*Please click here to review Program Terms and Conditions.

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SOTYKTU™ (deucravacitinib) 6 mg tablets

Coverage and Access to SOTYKTU

Support during the coverage determination process

After your patient is enrolled, their SOTYKTU Support Coordinator will:

RETURN TO HOME

FAX A SUMMARY OF BENEFITS FORM TO YOUR OFFICE AFTER COVERAGE IS VERIFIED

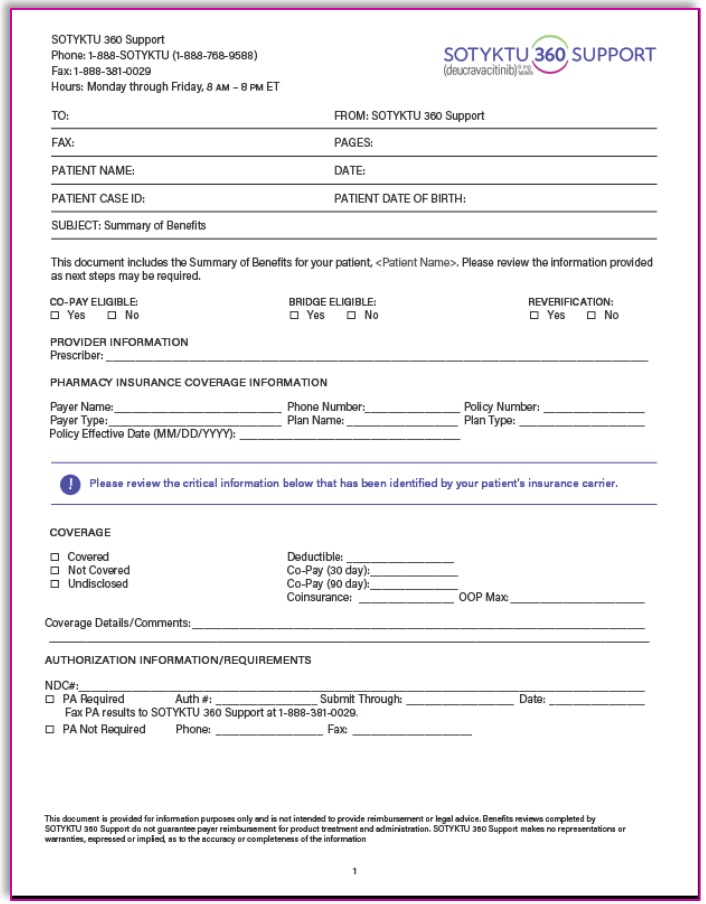
- Summary of Benefits form includes SOTYKTU out-of-pocket costs, expected coverage, PA requirements, and co-pay and bridge eligibility
- Results will be faxed to your office

PROVIDE PAYER-SPECIFIC PA FORMS AND ASSIST WITH APPEALS, IF NEEDED:

- Access template letters are available on SOTYKTUHCP.com

CALL YOUR PATIENTS TO HELP THEM UNDERSTAND:

- Information about their insurance coverage and out-of-pocket costs for SOTYKTU
- If they may be eligible for the SOTYKTU Co-Pay Assistance Program*
- Whether there may be other programs or resources to assist them with treatment access



SOTYKTU 360 Support
Phone: 1-888-SOTYKTU (1-888-768-9588)
Fax: 1-888-381-0029
Hours: Monday through Friday, 8 AM – 8 PM ET

SOTYKTU 360 SUPPORT (deucravacitinib) 6 mg tablets

TO: FROM: SOTYKTU 360 Support
FAX: PAGES:
PATIENT NAME: DATE:
PATIENT CASE ID: PATIENT DATE OF BIRTH:
SUBJECT: Summary of Benefits

This document includes the Summary of Benefits for your patient, <Patient Name>. Please review the information provided as next steps may be required.

CO-PAY ELIGIBLE: ☐ Yes ☐ No
BRIDGE ELIGIBLE: ☐ Yes ☐ No
REVERIFICATION: ☐ Yes ☐ No

PROVIDER INFORMATION
Prescriber: _____

PHARMACY INSURANCE COVERAGE INFORMATION
Payer Name: _____ Phone Number: _____ Policy Number: _____
Payer Type: _____ Plan Name: _____ Plan Type: _____
Policy Effective Date (MM/DD/YYYY): _____

Please review the critical information below that has been identified by your patient's insurance carrier.

COVERAGE
☐ Covered
☐ Not Covered
☐ Undisclosed
Deductible: _____
Co-Pay (30 day): _____
Co-Pay (90 day): _____
Coinsurance: _____ OOP Max: _____
Coverage Details/Comments: _____

AUTHORIZATION INFORMATION/REQUIREMENTS
NDC#: _____
☐ PA Required Auth #: _____ Submit Through: _____ Date: _____
Fax PA results to SOTYKTU 360 Support at 1-888-381-0029.
☐ PA Not Required Phone: _____ Fax: _____

This document is provided for information purposes only and is not intended to provide reimbursement or legal advice. Benefits reviews completed by SOTYKTU 360 Support do not guarantee payer reimbursement for product treatment and administration. SOTYKTU 360 Support makes no representations or warranties, expressed or implied, as to the accuracy or completeness of the information

1

*Please click here to review Program Terms and Conditions.

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Key areas of the Summary of Benefits form

SOTYKTU 360 SUPPORT during the coverage determination process

RETURN TO HOME

1

PATIENT ELIGIBILITY FOR SOTYKTU CO-PAY ASSISTANCE* AND/OR SOTYKTU BRIDGE PROGRAM* WILL BE INCLUDED ON THE SUMMARY OF BENEFITS FORM, IF APPLICABLE

2

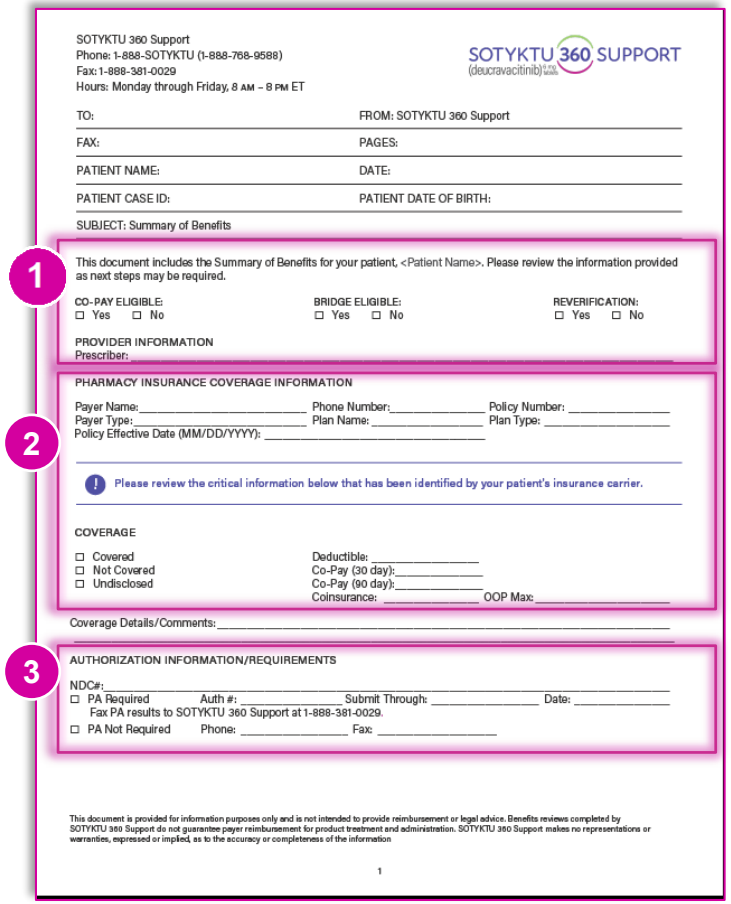
PRESCRIPTION COVERAGE MAY BE REPORTED AS: COVERED, NOT COVERED, OR UNDISCLOSED

- If covered, the report will include the patient's:
  - Deductible
  - Co-Pay and frequency of payment
    and/or
  - Coinsurance with an out-of-pocket maximum
- If not covered, or if a PA or formulary exception request is denied by the plan, it can be appealed;
  - Refer to the template letter of appeal on SOTYKTUHCP.com
  - If an NDC block is in place, a formulary exception letter may be submitted to request its removal. Refer to the template letter of formulary exception on SOTYKTUHCP.com
  - Additional payer-specific documents may be sent along with the Summary of Benefits form, if applicable

3

THE AUTHORIZATION INFORMATION REQUIREMENTS SECTION WILL INDICATE IF A PRIOR AUTHORIZATION (PA) IS REQUIRED:

- If a PA is required, the authorization number and how to submit the PA will be included
- Refer to the template letter of medical necessity and formulary exception letter on SOTYKTUHCP.com for potential next steps



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Phone: 1-888-SOTYKTU (1-888-768-9588)
Fax: 1-888-381-0029
Hours: Monday through Friday, 8 AM – 8 PM ET

SOTYKTU 360 SUPPORT (deucravacitinib) 6 mg tablets

TO: FROM: SOTYKTU 360 Support
FAX: PAGES:
PATIENT NAME: DATE:
PATIENT CASE ID: PATIENT DATE OF BIRTH:
SUBJECT: Summary of Benefits

1
This document includes the Summary of Benefits for your patient, <Patient Name>. Please review the information provided as next steps may be required.

CO-PAY ELIGIBLE: ☐ Yes ☐ No
BRIDGE ELIGIBLE: ☐ Yes ☐ No
REVERIFICATION: ☐ Yes ☐ No

PROVIDER INFORMATION
Prescriber:

2
PHARMACY INSURANCE COVERAGE INFORMATION
Payer Name: Phone Number: Policy Number:
Payer Type: Plan Name: Plan Type:
Policy Effective Date (MM/DD/YYYY):

Please review the critical information below that has been identified by your patient's insurance carrier.

COVERAGE
☐ Covered
☐ Not Covered
☐ Undisclosed
Deductible:
Co-Pay (30 day):
Co-Pay (90 day):
Coinsurance: OOP Max:
Coverage Details/Comments:

3
AUTHORIZATION INFORMATION/REQUIREMENTS
NDC#:
☐ PA Required Auth #: Submit Through: Date:
Fax PA results to SOTYKTU 360 Support at 1-888-381-0029.
☐ PA Not Required Phone: Fax:

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1

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SOTYKTU prior authorization and appeal checklist

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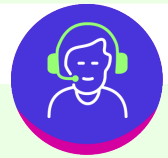
The checklist below highlights items and information that may help support a prior authorization (PA) decision from a patient's health insurance plan. Be sure to review the insurer's guidelines for obtaining a PA, as these can differ by insurer, the medication being prescribed, and other factors.

- Review the health plan's PA submission options
- Complete a PA request form
  (if required by patient's health plan)
- Provide documentation supporting the treatment decision
- Include patient prescription insurance information:
  - Copy the front and back of the prescription insurance card
- Confirm the health plan received the PA request
- Document the PA approval number and duration
- When you receive PA determination, please fax to your SOTYKTU Support Coordinator

covermymeds®

CoverMyMeds offers electronic PA support. An electronic PA is available for submitting and tracking prior authorizations.
To learn more, visit CoverMyMeds.com or call 1-800-705-9613



For additional information or assistance, please contact your SOTYKTU Support Coordinator at 1-888-SOTYKTU (768-9588)
8 AM to 8 PM ET, M-F

Please see Important Safety Information on slides 3-5 and full Prescribing Information, including Medication Guide, available at the end of this presentation.

Supporting Information and Access Template Letters

RETURN TO HOME

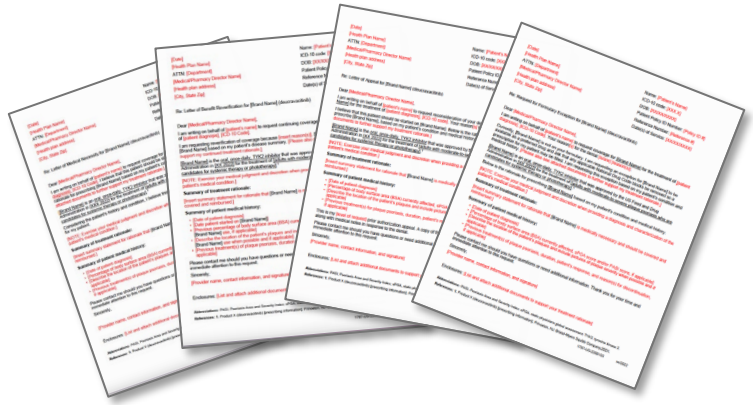
The following supporting information may be included within or accompany your communications to request coverage for SOTYKTU.

Clinical information to support the treatment decision, for example (if applicable):

- Percentage of body surface area affected
- sPGA score and/or PASI score
- Body location of plaques including pictures of plaque severity if possible
- Date of patient diagnosis
- ICD-10 code
- Previous treatment(s) of plaque psoriasis, duration, patient's response and reason(s) for discontinuation

Additional supporting information:

- Prescribing Information
- Journal articles or clinical guidelines



Download access letter templates

- Formulary exception letter
- Letter of appeal
- Letter of medical necessity
- Letter of reverification

The example templates above may be used to support requests for access to SOTYKTU. Information provided in the templates are for informational purposes for patients who have been prescribed SOTYKTU. Templates are not intended to substitute for a prescriber's independent, clinical decision-making. Completed letters must be submitted by the prescriber on the prescriber's letterhead, along with any relevant medical records.

*Abbreviations: PA, Prior Authorization; sPGA, static Physicians Global Assessment; PASI, Psoriasis Area and Severity Index; IGA, Investigator's Global Assessment

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Formulary exceptions overview

RETURN TO HOME

A formulary exception may be requested:

- To obtain access to a product that has been prescribed for a patient but is not included on a plan's formulary, or
- For removal of a utilization management requirement for a formulary product, such as:

Step Therapy (ST) / Step Edit (ED)

A payer process in which patients must first try one therapy before they are permitted to "step" to another drug

Prior Authorization (PA)

A process through which a request for provisional affirmation of coverage is submitted to the insurance provider for review before the item or service is furnished to the beneficiary and before the claim is submitted for processing

Quantity Limit (QL)

The highest amount of a prescription drug that can be given to your patient by their pharmacy in a specified period of time (for example, 30 tablets per month)

For additional information or assistance, please contact your SOTYKTU Support Coordinator at 1-888-SOTYKTU (768-9588) 8 AM to 8 PM ET, M-F

Handling appeals

RETURN TO HOME

If coverage for SOTYKTU is denied, the treating HCP or patient may submit an appeal. The process flow below highlights some options for pursuing an appeal:

Plan Guidelines

Refer to the health plan's specific guidelines for appeals, as the plan may have multiple levels of appeals with different requirements

Targeted Response

The appeal letter should provide the prescriber's clinical rationale as to why the product preferred on the insurer's formulary is not appropriate

For additional information or assistance, please contact your SOTYKTU Support Coordinator at 1-888-SOTYKTU (768-9588) 8 AM to 8 PM ET, M-F

Please see Important Safety Information on slides 3-5 and full Prescribing Information, including Medication Guide, available at the end of this presentation.

SOTYKTU Bridge Program

For commercially insured patients taking SOTYKTU who are denied or experience a delay in coverage

RETURN TO HOME

If denied coverage or experiencing a delay in coverage, commercially insured patients may be eligible to receive SOTYKTU at no cost for up to 3 years while awaiting a coverage determination*

The program begins when coverage is delayed after the initial submission of prior authorization (PA). If PA is denied, you must file an appeal within 90 days or per the payer requirements to keep your patient in the 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
- Submitting a Prior Authorization (PA) within 90 days of SOTYKTU Bridge Program enrollment
- 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 36 months (dispensed in 30-day prescriptions). Up to 12 months coverage for residents in Massachusetts, Minnesota, and Rhode Island
- A signed Patient Authorization and Agreement (PAA) is on file
- US residents only
- SOTYKTU Bridge Program is not available to patients who have prescription insurance coverage through Medicare, Medicaid, or any other federal or state program

*Please click here to review Program Terms and Conditions.

The accurate completion of reimbursement or coverage-related documentation is the responsibility of the healthcare provider and patient. Bristol-Myers Squibb and its agents make no guarantee regarding reimbursement for any service or item.

Please see Important Safety Information on slides 3-5 and full Prescribing Information, including Medication Guide, available at the end of this presentation.

SOTYKTU™ (deucravacitinib) 6 mg tablets

Patient Financial Support

SOTYKTU Co-Pay Assistance Program

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Commercially insured patients may **pay as little as $0 every month** for SOTYKTU with the SOTYKTU Co-Pay Assistance Card*

To enroll in the SOTYKTU Co-Pay Assistance Program, eligible patients can call their SOTYKTU Support Coordinator at **1-888-SOTYKTU (768-9588)** or self-enroll at SOTYKTUCoPaySignup.com**.** If a patient is uninsured or underinsured, their SOTYKTU Support Coordinator can discuss what options may be available to them

ELIGIBILITY REQUIREMENTS

- 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 and annual maximum program benefits apply and may vary from patient to patient, depending on the terms of a patient's prescription drug plan and based on factors determined solely by Bristol-Myers Squibb

CO-PAY ACTIVATION OPTIONS

- SOTYKTUCoPaySignup.com: Direct activation by patient
- QR Code on page 3 of the Start Form: Direct activation by patient via SOTYKTUCoPaySignup.com
- **1-888-SOTYKTU (768-9588)**: Direct activation by patient, or the SOTYKTU Support Coordinator may contact patient before submitting the prescription to the specialty pharmacy

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SOTYKTU 360 SUPPORT can help identify potential financial assistance programs for uninsured and underinsured patients

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Referrals to independent charitable foundations that may be able to assist eligible uninsured or underinsured patients who have an established financial hardship

Referrals to Low-Income Subsidy Program (Medicare Extra Help)

It is important to note that charitable foundations and the Low-Income Subsidy Program are independent from Bristol Myers Squibb and have their own eligibility criteria and evaluation process. Bristol Myers Squibb cannot guarantee that a patient will receive assistance.

Additional Resources

Get committed support

Have questions or need assistance? There are 3 ways to get support:

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CONTACT

Your **Access and Reimbursement Manager** for access and reimbursement assistance or to schedule a conversation

CALL

1-888-SOTYKTU (768-9588)
8 AM to 8 PM ET • Monday to Friday to speak with your SOTYKTU Support Coordinator

VISIT

SOTYKTUHCP.com for information and resources, including the enrollment form, to help your patients with access to SOTYKTU

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SOTYKTU select product information

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SOTYKTU prescriptions can be filled at any specialty pharmacy*

For the SOTYKTU Free Trial Offer and SOTYKTU Bridge Program, please enroll eligible patients in SOTYKTU 360 SUPPORT through CoverMyMeds.com or fax: 1-888-381-0029†

- **Indication:** SOTYKTU is indicated for the treatment of adults with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy
- NDC 0003-0895-11 30 ct tablets
- **ICD-10 Code:** L40.0
- The dosage strength of SOTYKTU is 6 mg in tablet form. The treatment schedule is one tablet of SOTYKTU, once daily
- SOTYKTU should be stored at 68°F to 77°F (20°C to 25°C) in the original container or blister pack

*Please be aware that some payers mandate a specific specialty pharmacy for SOTYKTU.

†Please click here to review Program Terms and Conditions.

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SOTYKTU 360 SUPPORT

Your circle of support

SOTYKTU™
(deucravacitinib) 6 mg tablets