Completing the SOTYKTU Start Form

FIRST | Fill out Section A on page 1 of the form with patient information

SECOND | Fill out Sections B-E on page 1 of the form with HCP information about you and your office, and treatment for your patient

THIRD | Obtain the patient signature and date at the bottom of the Patient Authorization and Agreement (PAA) on page 2

! 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.

PATIENT INFORMATION

Fill Out Start Form on **PAGE 1, SECTION A**

The Basics

As you fill out the form, be sure to complete all fields in Section A including:

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

Prescription Drug Insurance

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

Important Note for You and Your Patients:

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

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 6 mg
☐ 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 6 mg
☐ 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 6 mg
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; (4) I will not seek reimbursement for any free product provided to the patient; and (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

PATIENT SIGNATURE

Obtain Signature and Date on **PAGE 2**

Patient Authorization

It is required to obtain the patient signature and date for the Start Form to be processed.

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

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

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.

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Completing the SOTYKTU Start Form (cont'd)

HCP INFORMATION — Fill Out Start Form on **PAGE 1, SECTIONS B-E**

Prescriber Information

As you fill out the form, be sure to complete all fields in Sections B through E including:

- **Your name, address, and numbers:** Just as with the patient, your full name and phone number are required 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

Treatment Information

- **Diagnosis:** It is required to identify the patient's diagnosis
- **SOTYKTU Free Trial Offer*:** The Free Trial Rx for SOTYKTU includes a 30-day supply of SOTYKTU that is available at no cost to patients through SOTYKTU 360 SUPPORT. See the SOTYKTU Free Trial Offer full terms and conditions on page 3 of the Start Form or at SOTYKTU.com/terms-conditions
- **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 a coverage decision. See the SOTYKTU Bridge Program full terms and conditions on page 3 of the Start Form or at SOTYKTU.com/terms-conditions

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

NOTE: Once you have obtained the patient's signature on the PAA (page 2) and filled out page 1, the Start Form is complete and you can send it in.

*The SOTYKTU Free Trial Offer is eligible for new patients who have not previously received a sample or filled a prescription for SOTYKTU. Patients must have a valid 30-day prescription for SOTYKTU for an on-label indication. Patients must be 18 years of age or older and residents of the United States or a US territory. See the full terms and conditions on page 3 of the Start Form or at SOTYKTU.com/terms-conditions.

†The SOTYKTU Bridge Program is available at no cost for eligible, commercially insured, on-label diagnosed patients and whose prior authorization is denied or delayed, and is not contingent on any purchase requirement, for up to 36 months (dispensed in 30-day prescriptions). The SOTYKTU Bridge Program is not available to patients who have prescription insurance coverage through Medicare, Medicaid, or any other federal or state program, and is available for no more than 12 months to patients in MA, 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 on a rolling 12 month basis from the patient's first shipment date, and may be re-verified at other times during Program participation. Offer is not health insurance, and may be modified or discontinued at any time without notice. Once coverage is approved by the patient's commercial insurance plan, the patient will no longer be eligible. Other limitations may apply. See the full terms and conditions on page 3 of the Start Form or at SOTYKTU.com/terms-conditions.

Bristol Myers Squibb is committed to transparency. For information on the list price of SOTYKTU as well as information regarding average out-of-pocket costs and assistance programs, please visit our pricing information page at SOTYKTU.com/price.

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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