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: / /
Street Address where you live:	City:	State:	Zip Code:
Mailing address (if different from above)	City:	State:	Zip Code:
Social Security Number:	Phone number: ( )		
Gender: Male ◯ Female ◯	Contact Name:		

PATIENT ELIGIBILITY INFORMATION – ATTACH PROOF OF ANNUAL HOUSEHOLD INCOME (REQUIRED)

TOTAL ANNUAL HOUSEHOLD INCOME $
(include all annual income, Wages, Social Security, Pension, Disability, Interest Earned on Savings, etc.)
If you have indicated no income ($0), your application may be subject to audit or request for additional documentation.

Household Size (number of persons living in the home):

Private Insurance	Yes ◯	No ◯		Medicare A	Yes ◯	No ◯	
Prescription Drug Coverage	Yes ◯	No ◯		Medicare B	Yes ◯	No ◯	
Medicaid	Yes ◯	No ◯		Medicare D	Yes ◯	No ◯	
Have you applied for Medicaid in the past and been denied?	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, 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's Signature: _____ Date: _____

Advocate Signature: _____ Date: _____

HEALTHCARE PROVIDER INFORMATION TO BE COMPLETED BY THE PRESCRIBING PRACTITIONER

First Name:	Last Name:	Professional Designation:
State License Number:		
Shipping Address 1: (cannot ship to P.O. Box)		
Shipping Address 2:		
City:	State: Zip Code:	Diagnosis Code:
Contact Name:	Phone Number: ( )	Fax: ( )

REQUESTED MEDICATION (PLEASE CHOOSE):

☐ Abilify **Oral Solution 150 mL** ____ Qty / Day
☐ Abilify **2mg** ____ Qty / Day
☐ Abilify **5mg** ____ Qty / Day
☐ Abilify **10 mg** ____ Qty / Day
☐ Abilify **15mg** ____ Qty / Day
☐ Abilify **20 mg** ____ Qty / Day
☐ Abilify **30 mg** ____ Qty / Day

☐ Abilify 10mg **DISCMELT ®** ____ Qty / Day
☐ Abilify 15mg **DISCMELT ®** ___ Qty / 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, 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: _____