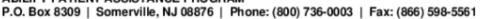
BRISTOL-MYERS SQUIBB PATIENT ASSISTANCE FOUNDATION, INC. ABILIFY PATIENT ASSISTANCE PROGRAM





PATIENT	INFORMA	TION					
First Name: MI: Last Name:					Date of Birth: / /		
Street Address where you live:	City:	City: Si		e:	Zip Code:		
Mailing address (if different from above)	City:	City: State		e:	Zip Code:		
Social Security Number:	Phone	Phone number: ()					
Gender: Male O Female O	Contact Name:						
PATIENT ELIGIBILITY INFORMATION - ATTACH P	ROOF OF	ANNUAL	HOUSEH	IOLD INCOME	(REQUIR	ED)	
TOTAL ANNUAL HOUSEHOLD INCOME \$ (include all annual income, Wages, Social Security, Pension							
*If you have indicated no income (\$0), your application may be Household Size (number of persons living in the home):	e subject to	audit or r	equest for	additional docu	umentation		
Private Insurance	Yes O	No O	Medicar	ρ Δ	Yes O	NoO	
Prescription Drug Coverage	Yes O	No O	Medicar		Yes	No O	
Medicaid	Yes	No O	Medicar		Yes	NoO	
Have you applied for Medicaid in the past and been					-		
denied?	Yes 🔘	No 🔘	VA or Mi	litary Benefits	Yes 🔘	No O	
statements made on my application. The BMSPAF and/or their agents ag	Date:						
HEALTHCARE PROVIDER INFORMATION TO BE COMPLETED BY THE PRESCRIBING PRACTITIONER First Name: Professional Designation:						R	
State License Number:							
Shipping Address 1: (cannot ship to P.O. Box)							
Shipping Address 2:	7in Code						
City: State:	Zip Code:			Diagnosis Code:			
Contact Name: Phone Number: () Fax: () REQUESTED MEDICATION (PLEASE CHOOSE):							
Abilify Oral Solution 150 mL Abilify 2mg Abilify 5mg Qty / Day Qty / Day	Abilify 10 mg	Abilif	y 15 mg Qty / Day	Abilify 20 mg Oty / Day	Abilify 30 o	mg / Day	
	ge in dose sche			_		ONO	
I represent that any information I have provided about this patient is comunderstand that the BMSPAF, and/or their agents are relying on this info coverage, including Medicaid, Medicare or other public or private program payment to any third-party payor (private or government) for the medical program at any time. My signature certifies that the medication received freturned for credit. I understand that BMSPAF reserves the right to recall or the control of the contro	mation. To the ms. I acknowled tion. I under the ms. I under the ms. I under the ms. I was a second to the ms. I was a sec	ne best of m edge and ag rstand that I will not be r	y knowledge gree not to s BMSPAF res esold nor of	b, this patient has a submit an insurance serves the right to fered for sale, trade	no prescription e claim or off modify or te	n insurance ner claim for rminate this	