Bristol-Myers Squibb

P.O. Box 4000 Princeton, NJ 08543-4000 609-252-4000
www.bms.com

August 1, 2018

RE: Supply Update on NULOJIX® (belatacept)

Dear Doctor,

This letter is to update you on the availability of NULOJIX® (belatacept) as it relates to previously communicated manufacturing-related supply constraints.

Bristol-Myers Squibb (BMS) has continued to closely monitor production capacity and demand projections to assess the need for maintaining the current restrictions on the prescribing of NULOJIX for new patients. While these restrictions have been in place, manufacturing output with the current manufacturing process has been enhanced, and inventory has been accumulated.

The combination of existing inventory and future production plans is enabling BMS to ease the prescribing restrictions for NULOJIX starting August 1, 2018 to allow for the expansion of use to appropriate new patients, if the treating physician determines that NULOJIX is the best treatment option for the patient.

BMS will continue to use the NULOJIX Distribution Program (NDP), and all patients (existing and new) must continue to be registered prior to ordering NULOJIX. New enrollment into the NDP will no longer be limited to new patients who have an urgent medical need and who have exhausted all other therapeutic options. Registration of all patients will help to ensure availability of NULOJIX for patients who have started therapy, and will also allow BMS to re-implement tighter restrictions on new patient enrollment in the future, if necessary. For additional information on the NDP, please visit www.NULOJIX.com.

The transplant team at BMS greatly appreciates the patience and understanding shown by prescribers and patients. BMS also recognizes that NULOJIX represents an important option for kidney transplant patients and remains committed to maintaining access for patients who require this life-saving therapy.

Sincerely,

Thomas Lehman, PharmD
US Medical Lead NULOJIX®
Bristol-Myers Squibb

Kellie Calderon, M.D.
Director, HQ Medical Immunoscience
Bristol-Myers Squibb

FORM 1

Nulojix Distribution Program

Phone: 855-511-6180 • **Fax:** 855-782-1233
Hours of Operation: Mon. – Fri. 8 am – 8 pm (Eastern Time)

Thank you for taking the time to complete this Nulojix Distribution Program Registration Form. All fields are required unless indicated with *optional*. Once the form is completed, please fax to: (855) 782-1233. If you have any questions, please contact the Nulojix Distribution Program at (855) 511-6180.

The program was developed to ensure continued access to Nulojix for existing patients. Once your patient has been admitted into the program, you will be provided a unique identification number for each patient. A unique patient identification number will be required to order Nulojix for a patient. The distributor will request this information.

PATIENT INFORMATION		
First Name:	Last Name:	
Address:		
City:	State:	Zip Code:
Phone Number: ( )	Date of Birth (mm/dd/yyyy):	

PATIENT REPRESENTATIVE INFORMATION ***(to be completed only if patient has a patient representative)***	
First Name:	Last Name:
Phone Number: ( )	Relationship to Patient:

PRESCRIBER INFORMATION		
First Name:	Last Name:	
Facility Name:	NPI Number:	
Address:		
City:	State:	Zip Code:
Phone Number: ( )	Fax Number: ( )	

INFUSING HEALTHCARE PROVIDER INFORMATION (*to be completed if different from above*)		
First Name:	Last Name:	
Facility Name:	NPI Number:	
Address:		
City:	State:	Zip Code:
Phone Number: ( )	Fax Number: ( )	

TREATMENT INFORMATION

Please indicate the therapy status: ☐ New to Therapy ☐ Existing Patient on Therapy

When did the patient start on therapy (mm/dd/yyyy): *(optional)* ____/____/____

I certify to the following: (1) To the best of my knowledge, the patient and healthcare provider information in this form is complete and accurate; (2) I have the authority to disclose this patient's information to Bristol-Myers Squibb and its respective agents and assignees, and I have obtained this patient's authorization for the disclosure, if required by HIPAA or other applicable privacy laws; and (3) I have determined based on my professional judgment that the Nulojix medication prescribed is medically necessary. If I am not the prescriber, I have consulted with prescriber to determine that the Nulojix medication is medically necessary. I will contact Nulojix Distribution Program at 855-511-6180 if the treatment for my patient changes in any way. I understand that the Nulojix Distribution Program may be discontinued or the rules for participation may change at any time, without notice.

Healthcare Provider Signature:	***Date:***

FORM 2

Nulojix Distribution Program

Phone: 855-511-6180 • **Fax:** 855-782-1233
Hours of Operation: Mon. – Fri. 8 am – 8 pm (Eastern Time)

Thank you for taking the time to complete this Nulojix Distribution Program Patient Authorization and Agreement form. All fields are required unless indicated as optional. Once the form is completed, please fax to: (855) 782-1233. If you have any questions, please contact the Nulojix Distribution Program at (855) 511-6180.

The Nulojix Distribution program was developed to ensure continued access to Nulojix for current patients. Your healthcare provider will be required to use a unique patient identification number to order Nulojix on your behalf.

PATIENT AUTHORIZATION and AGREEMENT

The Nulojix Distribution Program is a registration program by Bristol-Myers Squibb (BMS) that will manage the allocation of Nulojix to new and current users.

To participate in the Nulojix Distribution Program, the Program will need to receive, use, and disclose your personal information. Please read this authorization carefully, and contact Nulojix Distribution Program at 1-855-511-6180 if you have any questions. Once you have read and agreed to this form, fax your signed copy to 1-855-782-1233.

What information will be used and disclosed?

Information on the Nulojix Distribution Program Enrollment form, which includes:

• Patient Information • Healthcare Provider Information • Treatment Information

Who will disclose, receive, and use the information?

This authorization permits my caretakers, which includes my healthcare providers who provide services to me, as well as other people that I say can help me apply, to disclose my personal information to BMS, and its authorized agents and assignees ("Administrators") and distributors of Nulojix. BMS and its Administrators may also share my information with my caretakers as well as distributors of Nulojix. Your information will not be used for marketing purposes.

What is the purpose for the use and disclosure?

My personal information will be used by and shared with the persons and organizations described in this authorization in order to: • Process my application for the Nulojix Distribution Program • Provide the Nulojix Distribution Program services to me • Contact my caretakers and me about the programs and the services that are available • Improve or develop the programs' 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 cancel this authorization by writing to: Nulojix Distribution Program
P.O. Box 29052
Phoenix, AZ 85038-9052

If I cancel this authorization, I will no longer be able to participate in the program. The program will stop using or disclosing my information for the purposes listed in this authorization, except as necessary to end my participation or as required or allowed by law.

Notices

I understand that once my health information has been disclosed, privacy laws may no longer restrict its use or disclosure. BMS and its Administrators agree to use and disclose my information only for the purposes described in this authorization or as allowed or required by law. 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 my healthcare provider may not be able to order product through the Nulojix Distribution Program. I have a right to receive a copy of this authorization after I have signed it.

Patient Certifications

I certify that the personal information that I provide to the Nulojix Distribution Program is true and complete. I agree that, at any time during my participation in the program, the program may request additional documentation to verify my personal information. If there is missing information or I do not respond to requests for additional documents, my participation may be delayed or I may no longer be able to participate. I understand that I have to qualify for the program in order for my healthcare provider to be eligible to order Nulojix and that acceptance is based on supply. I understand that the Nulojix Distribution Program may be discontinued or the rules for participation may change at any time, without notice.

Print Patient or Patient Representative Name:	***Date of Birth:***
Patient or Patient Representative Signature:	***Date:***