SPRYCEL® Assist

Retail Patient Authorization and Agreement Form

PHONE: 1-855-777-9235

The patient support program for SPRYCEL® (dasatinib) (the "Program") is designed to provide you with reimbursement support services. To participate in the Program we will need to receive, use, and disclose your personal information. Please read this form carefully and contact Bristol-Myers Squibb ("BMS") at 1-855-777-9235 if you have questions. Fax the signed copy to 1-877-817-2975.

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 medications, biometric information, etc.), professional and employment information, financial and income information, insurance information, and information about the healthcare providers, pharmacists, health plans, and health insurers who provide services to me ("my caretakers").

Who will disclose, receive, and use the information?
This authorization permits my caretakers to disclose my personal information to BMS and their authorized agents and assignees. BMS and their authorized agents and assignees may also share it with my caretakers and with 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, determine my eligibility for the SPRYCEL Assist co-pay assistance program, refer me to other plans or assistance programs that may be able to help me and improve or develop the Program's services. The Program may also contact my service providers and me about the Program and the services that are available as well as contact other healthcare providers and charitable organizations to determine if I'm eligible for, or enrolled in, another plan or program.

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 whole or in part, in the future by writing to:

SPRYCEL® (dasatinib) Reimbursement
PO Box 220665
Charlotte, NC 28222-1509

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 does not sell or rent personal information collected about you 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

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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 to 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 it 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, I may call 1-855-961-0474 or complete the online form at www.bms.com/dpo/us/request.

Patient Certifications.

I certify that the personal information that I provide to the Program is true and complete. I agree that, at any time during my participation in the Program, Bristol-Myers Squibb and their agents may request additional documentation to verify my personal information. I understand that the Program may be discontinued or the rules for participation may change at any time, without notice.

I HAVE READ THIS AUTHORIZATION AND AGREE TO ITS TERMS:

Print Name of Patient or Personal Representative:

Description of Personal Representative's Authority:

Preferred Email Address: Zip:

Patient Date of Birth: Initials:

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE Date:

The patient or his/her personal representative must be provided with a copy of both pages of this form after it has been signed.

Bristol-Myers Squibb

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