START FORM INSTRUCTIONS

INSTRUCTIONS FOR PATIENTS

HOW TO GET STARTED WITH ZEPOSIA

1. **Read the Patient Authorization and Agreement on pages 1 and 2, and if you have commercial (private) insurance, read the ZEPOSIA Co-pay Program Terms and Conditions on page 5 of this form.**
2. **Fill out your information on page 3 of the Start Form. Be sure to complete sections 1, 2, and 3. And don't forget to:**
   - Provide your signature and the date as indicated on page 2
   - Check the box on page 2 to enroll in the ZEPOSIA co-pay offer (if eligible)
   - Check the box on page 2 to be a part of the ZEPOSIA 360 Support™ mobile program to receive important updates and information straight to your mobile device
3. **Your healthcare provider will fill out the rest of this form.** They'll complete page 4 of the Start Form and fax the completed version (pages 2, 3, and 4) to ZEPOSIA 360 Support.

WHAT TO EXPECT NEXT

1. You'll receive a phone call from a Nurse Navigator at ZEPOSIA 360 Support, a welcome email, and a text if you indicated you'd like to receive text messages.
2. Your Nurse Navigator will go over the next steps with you to help you get started.

If you don't hear from us, please reach out by calling the ZEPOSIA 360 Support program phone number below.

INSTRUCTIONS FOR HEALTHCARE PROVIDERS

HOW TO PRESCRIBE ZEPOSIA

1. **Once you've decided ZEPOSIA is right for your patient:**
   - Have your patient read the Patient Authorization and Agreement on pages 1 and 2, and if commercially insured, read the ZEPOSIA Co-pay Program Terms and Conditions on page 5 of this form to learn about a co-pay savings offer
   - Ensure your patient provides their signature and the date on page 2 and completes the required fields on page 3 of the Start Form
2. **Fill out page 4 of the Start Form and sign where designated.** Be sure to complete sections 4, 5, and 6 of this form and provide your signature and the date where indicated.
3. **Complete and fax pages 2, 3, and 4 to 1-833-727-7702.** Don't forget to double-check this form to make sure you and your patient have completed each field as required.
4. **Direct your patient to call ZEPOSIA 360 Support with any questions.** A Nurse Navigator will be available to answer questions and discuss next steps with your patient to help them get started with ZEPOSIA.

For questions, call:

ZEPOSIA 360 Support at **1-833-ZEPOSIA** (833-937-6742),
Monday to Friday, 8 AM - 8 PM ET **or visit ZEPOSIA.com**

PATIENT AUTHORIZATION AND AGREEMENT

The Bristol-Myers Squibb Company ZEPOSIA 360 Support™ program is a support program by Bristol-Myers Squibb Company (BMS) that helps patients understand their insurance coverage and financial support options for ZEPOSIA® (ozanimod), provides co-pay and free medication support to qualified patients, and provides educational, nurse, lab, and diagnostic support services. To participate in the Program, BMS will need to receive, use, and disclose your personal information. Please read this authorization carefully, and contact ZEPOSIA 360 Support at 1-833-ZEPOSIA (833-937-6742) if you have any questions. Once you have read and agreed to this form, fax your signed copy to 833-727-7702.

1. What information will be used and disclosed?
My personal information will be disclosed, including:

- Information on the Program enrollment form
- Contact information and phone carrier/device information (for calls and texts)
- Date of birth and Social Security Number (SSN is voluntary)
- Professional and employment information
- Financial and income information
- Insurance information
- Health records and information, including diagnoses, medications, and lab tests
- Biometric and genetic information, including tests that identify the kind of illness that I have and/or medication indicated for my treatment

2. Who will disclose, receive, and use the information?
This authorization permits my Health Caretakers, which include my healthcare providers, pharmacies, lab service providers, diagnostic service providers, health plans, and health insurers who provide services to me, as well as other people who I say can help me apply, to disclose my personal information to BMS, the third parties it works with, and other authorized agents, subsidiaries, and assignees (collectively "BMS"). BMS may also share my information with my Health 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.

3. 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 ZEPOSIA 360 Support services and provide the Program services to me, including verifying my insurance benefits, assistance with prior authorizations from my insurance, researching alternative insurance coverage options, providing information and education about the services through a case manager, and referring me and my Health Caretakers to other plans, support, or assistance programs that may be able to help me with access to my medication
- Provide me with healthcare services, including lab and diagnostic tests and related healthcare procedures related to ZEPOSIA. I understand these healthcare services are not provided, or employed, by my healthcare professional. I understand that my insurance may be billed for these services and that I may have a separate co-pay or cost-sharing obligation for using these services
- Provide co-pay assistance and/or free medication to me, if I am eligible
- Receive, and/or purchase, my information (including information about my prescriptions and insurance claims) from my Health Caretakers to determine if and where I am receiving my medication and whether I am no longer eligible for free medication or other BMS support programs
- Contact my Health Caretakers and me about the programs and the services that are available
- Contact other healthcare providers and charitable organizations to determine if I am eligible for, or enrolled in, another plan or program
- Contact me for marketing purposes, including providing me with information about my medication, refill reminders, surveys, and other information and alerts that BMS believes may be of interest to me (and some of which may be sent directly to my phone if I choose)
- Improve or develop the Program's services and other internal business purposes including analytics

Authorization for Sale of My Information to BMS:
I authorize my Health Caretakers (including my healthcare providers, health plans, health insurers, pharmacies, lab service providers, and diagnostic service providers) to disclose my information for the purposes described in this authorization, and I further authorize my Health Caretakers to accept payment from BMS in exchange for providing my information.

4. 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: ZEPOSIA 360 Support, PO Box 220734, Charlotte, NC 28222. 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. I understand that if I receive free medication, I must re-apply at least every year, sign this authorization again, and be accepted.

Please see Important Safety Information on page 6 and full Prescribing Information and Medication Guide.

PATIENT AUTHORIZATION AND AGREEMENT (CONT'D)

5. **Notices:** I understand that once my health information has been disclosed, privacy laws may no longer restrict its use, disclosure, or further re-disclosures. BMS may use and disclose my information for the purposes described in this authorization or as allowed or required by law. I understand that BMS does not sell or rent personal information collected about me from this Program. I have a right to receive a copy of this authorization after I have signed it. 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 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 I may not receive a response to 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 my request to receive access to, or deletion of, my information will be honored. I will not be discriminated against for exercising my rights, but I understand that I may not be able to receive Program services if I do not allow use of my information. To submit an access or deletion request, I may call 1-833-ZEPOSIA (833-937-6742) or complete the online form at www.bms.com/dpo/us/request.
6. **Patient certifications:** I certify that the personal information that I provide to BMS is true and complete. I agree that, at any time during my participation, BMS 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. If I qualify for, and receive, co-pay assistance or free medication assistance from BMS, I agree to comply with the Program rules on your enrollment form and I will not get reimbursed for the assistance I receive from anyone else, including from an insurance program, another charity, or a health savings, flexible spending, or other health reimbursement account. I understand that assistance may be temporary and that I may be required to apply every year. I will contact the Program at 1-833-937-6742 if my insurance or treatment changes in any way. If I have Medicare Part D, I will also not count any free medication I receive toward my true out-of-pocket (TrOOP) costs. I understand that the Program may be discontinued or the rules for participation may change at any time without notice.
7. **Consent for autodialed calls and texts (optional):** I authorize the receipt of autodialed calls and text messages from the Program. I understand that my authorization is not a condition of purchase, or use, of ZEPOSIA® (ozanimod) or any other BMS product and that the Program is valid with most major US carriers. I understand that my carrier's message and data rates may apply. I understand that information BMS obtains from me in connection with use of autodialed calls and text messages is used by the Program under the terms of this authorization. I can stop autodialed calls and text messages at any time by calling ZEPOSIA 360 Support at 1-833-ZEPOSIA (833-937-6742). I can also stop text messages by texting "STOP" to 763-600-7990 or the phone number from which I received a text message. For help, I can text "HELP" to 763-600-7990 or the phone number from which I received a text message.

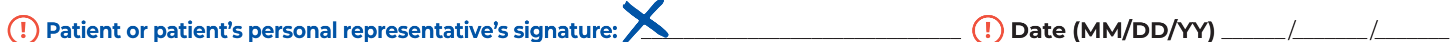
The patient or his/her personal representative must be provided with a copy of both pages of this form after it has been signed.

PATIENT APPROVAL

☐ **If eligible, I would like to enroll in the ZEPOSIA Co-pay Program.**
I have read and agreed to the program terms and conditions on page 5, and understand that co-pay assistance is only available for commercially insured patients and does not apply if I have prescription drug coverage through a federal, state, VA, or similar program.

☐ **I would like to receive text messages and calls.**
I have read and agreed to receive text messages and calls as explained in the Consent for autodialed calls and texts (see above).

I have read and agreed to the Patient Authorization and Agreement on pages 1 and 2 of this form.



PATIENT:

Please provide all information in the blue sections (1 through 3) below.

(!) Indicates a field that MUST be completed for this form to be processed.

1 PATIENT INFORMATION

☐ Male
☐ Female
☐ Other

(!) **First name** ________________ **MI** ______ (!) **Last name** ________________ (!) **Date of birth** ____/_____/_______

Address *(No PO Box)* ______________________________________ **City** ____________________

State ________ **ZIP** ____________ **E-mail address** ______________________________________

(!) **Mobile phone** ____________________ **Home phone** ____________________ ☐ OK to leave voicemail

Preferred contact number: ☐ Mobile ☐ Home **Preferred time:** ☐ Morning ☐ Afternoon ☐ Evening

Primary language: ☐ English ☐ Spanish ☐ Other ______________________________

Name of care partner/alternate contact* ______________________________________

Care partner/alternate contact phone ______________________________ ☐ OK to leave voicemail

*By providing the name and contact information of this individual, I am authorizing the disclosure of my health information to him/her.

2 MEDICAL INSURANCE COVERAGE

☐ **See attached copy of my insurance card(s) for the information requested below.**

(!) **Primary insurance carrier** ______________________________ (!) **Policy #** ____________

Group # ____________ **Insurance phone** ____________ **Policyholder name (First, Last)** ____________________

☐ Patient has no insurance

Secondary insurance carrier ______________________________ **Policy #** ____________

Group # ____________ **Insurance phone** ____________ **Policyholder name (First, Last)** ____________________

3 PRESCRIPTION INSURANCE COVERAGE

☐ **See attached copy of my insurance card(s) for the information requested below.**

Prescription insurance carrier ____________________ **Rx Member ID** ________ **Insurance phone** ____________

Rx PCN (if applicable) ____________ **Rx Group ID** ____________ **Rx BIN (if applicable)** ____________

☐ Patient has no insurance

☐ Patient does not have a separate plan for prescription insurance; these benefits are included in patient's medical insurance plan

ZEPOSIA® (ozanimod) 0.92 mg capsules | 360 SUPPORT™

START FORM

TO HEALTHCARE PROVIDER: Fax the completed Start Form, a copy of insurance card, AND pharmacy benefit card (both sides of each) to **1-833-727-7702** or enroll online at **www.ZEPOSIAportal.com**

Patient: First name ____________ **Last name** ____________ **Date of birth** ____/____/____

HEALTHCARE PROVIDER:

Please provide all information in the red sections (4 through 6) below. (!) Indicates a field that MUST be completed for this form to be processed. If you need help, please call ZEPOSIA 360 Support™ at 1-833-ZEPOSIA (833-937-6742).

4 PRESCRIBER INFORMATION

(!) **First name** ____________ (!) **Last name** ____________ **Facility name** ____________

(!) **Address** ____________ (!) **City** ____________ (!) **State** ____________ (!) **ZIP** ____________

(!) **Phone** ____________ **Fax** ____________ (!) **NPI #** ____________ (!) **State medical license #** ____________

E-mail address ____________ **Office contact name** ____________ **Best time to contact:** ☐ Morning ☐ Afternoon

5 ASSESSMENT ASSISTANCE REQUESTED

Check boxes to request assistance*:

In-home blood tests:
☐ CBC ☐ LFTs ☐ VZV antibody serology

Screenings:
☐ In-home ECG ☐ Help finding a provider for a macular edema assessment

No assistance requested, and I confirm:
☐ All assessments are completed ☐ Assessments not yet completed

*Available for on-label commercially insured patients only. This offer is not valid for medical assessments for which payment may be made in whole or in part under federal or state health programs, including but not limited to Medicare or Medicaid, and for residents in MA, MI, MN, and RI. This program is subject to termination or modification at any time.

6 TREATMENT INFORMATION AND PRESCRIBER AUTHORIZATION[†] (COMPLETE ALL PARTS THAT APPLY)

(!) **Primary diagnosis:** ☐ ICD-10: G35 ☐ Other ____________

Current/most recent MS therapy: ____________ (MM/YY) ____/____ to ____/____

Other MS therapy: ____________ (MM/YY) ____/____ to ____/____

Has patient already initiated ZEPOSIA® (ozanimod)? **Please check:** ☐ **Yes, start date** (MM/YY) ____/____ ☐ **No**

(!) Initiation Rx:

Days 1-4: Take ZEPOSIA 0.23 mg by mouth once daily
Days 5-7: Take ZEPOSIA 0.46 mg by mouth once daily
Day 8 and thereafter: Take ZEPOSIA 0.92 mg by mouth once daily

Check one:
For new patients:
☐ Dispense Starter Kit[‡] 7-day Starter Pack, followed by 30-day supply, 0 refills

For patients who are restarting:
☐ Dispense 7-day Titration Pack only, 0 refills

[‡]Starter Kit Rx is only for on-label patients who will not receive a sample from their prescriber.

Starter Kit or Titration Pack should be sent to:
☐ Prescriber address (see above)

If assessments are completed[§]:
☐ Patient address (see page 3) ☐ Alternate patient address (provide below)

Address ____________ **City** ____________

State ____________ **ZIP** ____________ **Phone** ____________

[§]Assessments must be complete and confirmed by provider to ship Starter Kit or Titration Pack directly to patient.

(!) Maintenance Rx (check one):

ZEPOSIA 0.92 mg by mouth once daily:
☐ Dispense 30-day supply followed by 11 refills or ____ refills
☐ Dispense 90-day supply followed by 3 refills or ____ refills

Rx to be dispensed at commercial specialty pharmacy:
☐ Transmit Rx to specialty pharmacy (provide name of specialty pharmacy):
____

Additional notes: ____________

Bridge Supply Rx[||] (optional for commercially insured patients):

ZEPOSIA 0.92 mg by mouth once daily:
☐ Dispense 30-day supply followed by up to 11 refills

[||]Bridge Supply Rx is available at no cost for eligible commercially insured, on-label diagnosed patients if there is a delay in determining whether commercial prescription coverage is available, and is not contingent on any purchase requirement. Bridge Supply Rx is not available to patients who have prescription insurance coverage through Medicare, Medicaid, or any other federal or state program, or MA or MI residents, and is available for no more than 6 months (180 days) to patients in 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 in January for patients continuing into the following year, and may be at other times during Program participation. Up to 12 additional refills may be provided if needed. Offer is not health insurance, and may be modified or discontinued at any time without notice. Other limitations may apply. In section 6 of this form above, please indicate if you are prescribing the Starter Kit or if the patient has already initiated ZEPOSIA.

PRESCRIBER AUTHORIZATION

I certify that I have (1) prescribed ZEPOSIA 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; and (4) I will not seek reimbursement for any free product provided to the patient. I authorize the ZEPOSIA 360 Support program to transmit the prescription(s) above to the appropriate dispensing pharmacy.

[†]If required by applicable law, please attach copies of all prescriptions on official state prescription forms.

(!) **Prescriber signature:** ____________ (!) **Date (MM/DD/YY)** ____/____/____

ZEPOSIA CO-PAY PROGRAM TERMS AND CONDITIONS

1. The ZEPOSIA Co-pay Program is valid only for patients with commercial (private) insurance prescribed ZEPOSIA® (ozanimod) for an FDA-approved indication. The Program includes a prescription benefit offer for out-of-pocket drug costs and a medical assessment benefit offer for out-of-pocket costs for the initial blood tests, and ECG screening where the full cost is not covered by the patient's insurance.
2. Patients are not eligible for the prescription benefit offer if they have prescription insurance coverage through a state or federal healthcare program, including but not limited to Medicare, Medicaid, MediGap, CHAMPUS, TRICARE, Veterans Affairs (VA), or Department of Defense (DoD) programs. Patients are not eligible for the medical assessment benefit offer if they have insurance coverage for their prescription or medical assessment through a state or federal healthcare program, or reside in Massachusetts, Michigan, Minnesota, or Rhode Island. Patients who move from commercial plans to state or federal healthcare programs will no longer be eligible.
3. Patient must be 18 years of age or older.
4. Patients pay as little as $0 in out-of-pocket costs per prescription, subject to a maximum benefit of $18,000 during a calendar year. Patients pay as little as $0 in out-of-pocket costs for the medical assessment, subject to a maximum benefit of $2,000. Patients are responsible for any costs that exceed the maximum amounts.
5. To receive the medical assessment benefit, an Explanation of Benefits (EOB) form must be submitted, along with copies of receipts for any payments made. This benefit is available without obligation to continue with ZEPOSIA therapy.
6. The Program expires on December 31, 2021.
7. All Program payments are for the benefit of the patient only.
8. Patients, pharmacists, and prescribers may not seek reimbursement from health insurance, health savings or flexible spending accounts, or any third party for any part of the prescription or medical assessment benefit received by the patient through this Program.
9. Patient's acceptance of any Program benefit confirms that it is consistent with the patient's insurance and that the patient will report the value received as may be required by his/her insurance provider.
10. Program valid only in the United States and Puerto Rico. Void where prohibited by law, taxed, or restricted.
11. The Program cannot be combined with any other offer, rebate, coupon, or free trial.
12. The Program is not conditioned on any past, present, or future purchase, including refills.
13. The Program is not insurance.
14. Bristol-Myers Squibb Company reserves the right to rescind, revoke, or amend this Program at any time without notice.

IMPORTANT SAFETY INFORMATION

INDICATION

ZEPOSIA® (ozanimod) is a prescription medicine used to treat relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

It is not known if ZEPOSIA is safe and effective in children.

IMPORTANT SAFETY INFORMATION

Do not take ZEPOSIA if you:

- have had a heart attack, chest pain (unstable angina), stroke or mini-stroke (transient ischemic attack or TIA), or certain types of heart failure in the last 6 months
- have or have had a history of certain types of an irregular or abnormal heartbeat (arrhythmia) that is not corrected by a pacemaker
- have untreated, severe breathing problems during your sleep (sleep apnea)
- take certain medicines called monoamine oxidase (MAO) inhibitors

Talk to your healthcare provider before taking ZEPOSIA if you have any of these conditions or do not know if you have any of these conditions.

ZEPOSIA may cause serious side effects, including:

- **Infections.** ZEPOSIA can increase your risk of serious infections that can be life-threatening and cause death. ZEPOSIA lowers the number of white blood cells (lymphocytes) in your blood. This will usually go back to normal within 3 months of stopping treatment. Your healthcare provider may do a blood test of your white blood cells before you start taking ZEPOSIA.

  Call your healthcare provider right away if you have any of these symptoms of an infection during treatment with ZEPOSIA and for 3 months after your last dose of ZEPOSIA:
  - fever
  - feeling very tired
  - flu-like symptoms
  - cough
  - painful and frequent urination (signs of a urinary tract infection)
  - rash
  - headache with fever, neck stiffness, sensitivity to light, nausea, or confusion (symptoms of meningitis, an infection of the lining around your brain and spine)

  Your healthcare provider may delay starting or may stop your ZEPOSIA treatment if you have an infection.
- **Slow heart rate (also known as bradyarrhythmia) when you start taking ZEPOSIA.** ZEPOSIA may cause your heart rate to temporarily slow down, especially during the first 8 days. You will have a test to check the electrical activity of your heart called an electrocardiogram (ECG) before you take your first dose of ZEPOSIA.

  Call your healthcare provider if you experience the following symptoms of slow heart rate:
  - dizziness
  - lightheadedness
  - feeling like your heart is beating slowly or skipping beats
  - shortness of breath
  - confusion
  - chest pain
  - tiredness

  Follow directions from your healthcare provider when starting ZEPOSIA and when you miss a dose.

Continue reading for additional possible serious side effects of ZEPOSIA.

Before taking ZEPOSIA, tell your healthcare provider about all of your medical conditions, including if you:

- have a fever or infection, or are unable to fight infections due to a disease, or take or have taken medicines that lower your immune system
- before you start ZEPOSIA, your healthcare provider may give you a chickenpox (varicella zoster virus) vaccine if you have not had one before
- have had chickenpox or have received the vaccine for chickenpox. Your healthcare provider may do a blood test for the chickenpox virus. You may need to get the full course of the vaccine and wait 1 month before taking ZEPOSIA
- have a slow heart rate
- have an irregular or abnormal heartbeat (arrhythmia)
- have a history of stroke
- have or have had heart problems, including a heart attack or chest pain
- have high blood pressure
- have liver problems
- have breathing problems, including during your sleep
- have eye problems, especially an inflammation of the eye called uveitis
- have diabetes
- are or plan to become pregnant or if you become pregnant within 3 months after you stop taking ZEPOSIA. ZEPOSIA may harm your unborn baby. If you are a female who can become pregnant, talk to your healthcare provider about what birth control method is right for you during your treatment with ZEPOSIA and for 3 months after you stop taking ZEPOSIA
- are breastfeeding or plan to breastfeed. It is not known if ZEPOSIA passes into your breast milk. Talk to your healthcare provider about the best way to feed your baby if you take ZEPOSIA

Tell your healthcare provider about all the medicines you take or have recently taken, including prescription and over-the-counter medicines, vitamins, and herbal supplements. Using ZEPOSIA with other medicines can cause serious side effects. Especially tell your healthcare provider if you take or have taken:

- medicines that affect your immune system, such as alemtuzumab
- medicines to control your heart rhythm (antiarrhythmics) or heartbeat
- strong CYP2C8 inhibitors such as gemfibrozil or clopidogrel
- medicines that inhibit breast cancer resistance protein transporters, such as cyclosporine and eltrombopag
- CYP2C8 inducers such as rifampin
- opioids (pain medicine), medicines to treat depression, and medicines to treat Parkinson's disease

You should not receive **live** vaccines during treatment with ZEPOSIA, for at least 1 month before taking ZEPOSIA and for 3 months after you stop taking ZEPOSIA. Vaccines may not work as well when given during treatment with ZEPOSIA.

ZEPOSIA can cause serious side effects, including:

- **liver problems.** Your healthcare provider will do blood tests to check your liver before you start taking ZEPOSIA. Call your healthcare provider right away if you have any of the following symptoms:
  - unexplained nausea
  - vomiting
  - stomach area (abdominal) pain
  - tiredness
  - loss of appetite
  - yellowing of the whites of your eyes or skin
  - dark-colored urine
- **increased blood pressure.** Your healthcare provider should check your blood pressure during treatment with ZEPOSIA. A sudden, severe increase in blood pressure (hypertensive crisis) can happen when you eat certain foods that contain high levels of tyramine
- **breathing problems.** Some people who take ZEPOSIA have shortness of breath. Call your healthcare provider right away if you have new or worsening breathing problems
- **a problem with your vision called macular edema.** Your risk of macular edema is higher if you have diabetes or have had an inflammation of your eye called uveitis. Your healthcare provider should test your vision before you start taking ZEPOSIA if you are at higher risk for macular edema or any time you notice vision changes during treatment with ZEPOSIA. Call your healthcare provider right away if you have any of the following symptoms:
  - blurriness or shadows in the center of your vision
  - sensitivity to light
  - a blind spot in the center of your vision
  - unusually colored vision
- **swelling and narrowing of the blood vessels in your brain.** Posterior Reversible Encephalopathy Syndrome (PRES) is a rare condition that has happened with ZEPOSIA and with drugs in the same class. Symptoms of PRES usually get better when you stop taking ZEPOSIA. If left untreated, it may lead to stroke. Your healthcare provider will do a test if you have any symptoms of PRES. Call your healthcare provider right away if you have any of the following symptoms:
  - sudden severe headache
  - sudden confusion
  - sudden loss of vision or other changes in your vision
  - seizure
- **severe worsening of MS after stopping ZEPOSIA.** When ZEPOSIA is stopped, symptoms of MS may return and become worse compared to before or during treatment. Always talk to your healthcare provider before you stop taking ZEPOSIA for any reason. Tell your healthcare provider if you have worsening symptoms of MS after stopping ZEPOSIA.
- **allergic reactions.** Call your healthcare provider if you have symptoms of an allergic reaction, including a rash, itchy hives, or swelling of the lips, tongue, or face

The most common side effects of ZEPOSIA can include:

- upper respiratory tract infections
- elevated liver enzymes
- low blood pressure when you stand up (orthostatic hypotension)
- painful and frequent urination (signs of urinary tract infection)
- back pain
- high blood pressure

These are not all of the possible side effects of ZEPOSIA. For more information, ask your healthcare provider or pharmacist.

Call your healthcare provider for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

Please see full Prescribing Information, including Medication Guide.

ZEPOSIA 360 SUPPORT™ FAX: 1-833-727-7702 | PHONE: 1-833-ZEPOSIA (833-937-6742)

Please see full Prescribing Information and Medication Guide.

Bristol Myers Squibb™

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