

YOUR YERVOY[®] (ipilimumab) ACTION PLAN

(to be filled out by a member of your oncology team)

Patient Name _____ **Date** _____
Full Name *Today's Date*

Side effects discussed _____

Key points _____

BMS RESOURCES

Financial Assistance

- BMS Access Support
1-800-861-0048
<http://www.bmsaccesssupport.bmscustomerconnect.com/patient>