MerckHelps™

MERCK PATIENT ASSISTANCE PROGRAM

Send completed, signed, and dated enrollment forms (applications) to:
Merck Patient Assistance Program, PO Box 690, Horsham, PA 19044
For inquiries, please call 800-727-5400

PROGRAM INFORMATION

As part of its commitment to patients and health care providers, the Merck Patient Assistance Program, Inc. (PAP) provides certain Merck medicines free of charge to people who do not have prescription drug or health insurance coverage and who, without our assistance, cannot afford their Merck medicines.

Applying to PAP is ***FREE***. Merck is not associated with any individuals or organizations who may charge patients a fee to assist them in completing enrollment forms for PAP. These individuals or organizations are acting independently of Merck, and do not have Merck's consent.

To be eligible for PAP, both the prescribing health care professional AND the patient must complete, sign, and date this program application form and certify that:

1. A health care provider has prescribed the patient a Merck medicine covered in the Merck Patient Assistance Program.

2. The patient currently resides in the United States (the patient does not need to be a U.S. citizen).

3. The patient does not have health insurance or other coverage for prescription medicines, or for the Merck medicine prescribed by their health care professional. Examples of health insurance include:

a. Private insurance
b. Health Maintenance Organizations (HMOs)
c. Medicaid or Medicare Part D
d. Veterans assistance, or any other social service agency support

AND

4. The patient cannot afford to pay for the Merck medicine and PAP can verify the patient meets the Program's financial eligibility criteria. Information about specific financial criteria levels is available by calling 1-800-727-5400.

5. For the most current list of Merck medicines available through this Program, please visit merckhelps.com, or call the Merck Patient Assistance Program at 1-800-727-5400. Specialists are available to assist you Monday through Friday, 8 AM to 8 PM ET.

PROGRAM CHECKLIST

1. Both the patient and the prescribing health care professional must complete all sections of this form.

2. Both the patient and the prescribing health care professional must sign AND date this form in all designated places.

3. The patient must authorize PAP to verify their current gross annual household income (household income before taxes are withdrawn) by either:

a. OPTION 1: Authorizing PAP and other individuals involved in administering the PAP to obtain his/her consumer report and/or other information related to his/her credit report to determine the patient's eligibility to participate in the program. This verification will not affect the patient's credit rating.

OR

b. OPTION 2: Sending with this application, a COPY of any ONE of the following documents showing proof of the household income the patient provided on the application form:

- Most recent 1040 Federal Tax Form
- One month of pay stubs, prior to the application date
- Social Security Benefits Letter
- Veteran Benefits Statement
- Unemployment Benefit Statement
- Disability Statement
- Pension Letter
- Letter from an employer

If selecting option 2, include a COPY of any ONE of these documents with your completed, signed, and dated enrollment form. Please do not send an original document.

4. Mail your completed, signed, and dated enrollment form in the enclosed business reply envelope. If you chose option 2 to verify household income, remember to include a copy of one of the documents listed above. You may also use your own envelope addressed to:

Merck Patient Assistance Program | PO Box 690 | Horsham, PA 19044

Scan to learn more about Merck's Patient Assistance Programs at MerckHelps.

MERCK PATIENT ASSISTANCE PROGRAM ENROLLMENT FORM

PATIENT MUST COMPLETE THIS SIDE OF FORM AND SIGN IN ALL PLACES WITH A SIGN HERE

SECTION 1: COMPLETE THE PATIENT INFORMATION BELOW. PLEASE PRINT IN LEGIBLE CAPITAL LETTERS.

USE A BLACK OR BLUE PEN

Patient's First Name

US Resident* ☐ Yes ☐ No **You do not have to be a US citizen*

Patient's Last Name

Address Line 1

Address Line 2 (Apartment/Unit Number)

City State Zip

Date of Birth I am enrolling for the first time I am re-enrolling

Provide an email address and a mobile phone number so we may contact you with program notifications and updates

Mobile Phone Home Phone

Email

Provide current gross annual household income (your income before taxes), including Social Security and pension benefits

Total Gross Annual Household Income $,

Number of Household Members (Including Patient) Who Depend on This Income

Do you have insurance or other prescription drug coverage? YES ☐ NO ☐

Are you enrolled in any of the following?: ☐ Medicare ☐ Medicaid ☐ Medicare Part D ☐ Other

I would like my product shipped to: ☐ My Home ☐ My Physician's Office

☐ Other Address:_____

Special delivery instructions:_____

Section 2: Income Verification

I understand the Merck Patient Assistance Program, Inc. (Merck PAP) will verify information about my current gross annual household income in order to ensure I am qualified for this program.

By signing below, I am providing written authorization to Merck PAP and other individuals involved in administering the Merck PAP to obtain my consumer report and/or other information related to my credit report to determine my eligibility to participate in the program. This verification will not affect my credit rating.

SIGN HERE **Patient's Original Signature** **Date** M M D D Y Y Y Y

NOTE: As an alternative to the above authorization, you may send any ONE of the documents listed on the cover page of this application form to verify the household income you provided on this form.

You must include a **copy** of this Income Verification Document with your completed and signed enrollment form. These can be sent to Merck PAP either in the attached return envelope or a self-addressed envelope to: Merck Patient Assistance Program, P.O. Box 690 Horsham, PA 19044.

Patient's First Name | Patient's Last Name

Section 3: Declarations and Authorization

Applicant Declarations and Authorization

I certify that all of the information provided in this application, including household income, is complete and accurate. I understand that program assistance will terminate if the program becomes aware of any fraud or if this medication is no longer prescribed for me. I understand that completing this application does not ensure that I will qualify for this program. I certify that I cannot afford this medication. I certify that I will not seek reimbursement or credit for this prescription from any insurer, health plan, or government program. If I am a member of a Medicare Part D plan, I will not seek to have this prescription or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs. I understand that Merck Patient Assistance Program (PAP) reserves the right to modify the application form, modify or discontinue this program, or terminate assistance at any time and without notice. I understand that Merck PAP reserves the right to conduct periodic audits and to request documentation to verify the information provided in this application. I authorize Merck PAP and its affiliates to forward this prescription to a dispensing pharmacy on my behalf. Merck PAP is not acting as a dispensing pharmacy. Merck PAP is not responsible for verifying any information contained in Section 2, including, without limitation, allergies, medical conditions, or other medications being taken by me. With respect to this application, I understand that only the dispensing pharmacy will be responsible for the information contained in Section 2 of this application form. I understand that assistance received through the Merck PAP is not insurance.

SIGN HERE **Patient's Original Signature** _____ **Date** M M D D Y Y Y Y

Applicant Authorization for Use and Disclosure of Personal Health Information

By signing below, I authorize my health care provider(s) and my health plan(s), including Medicare, to disclose to the Merck Patient Assistance Program and other individuals involved in administering the Merck Patient Assistance Program (collectively, the "PAP") my personal health information, including the information provided by my health care provider on the PAP Application form and other information related to my participation in the PAP (collectively, "My Information"), so that the PAP may use the information to (i) assess my qualification for the PAP, (ii) provide me with PAP assistance, (iii) administer the PAP, (iv) monitor, audit, access and evaluate the PAP's implementation and effectiveness, and (v) contact me via mail, email, text message, phone, or fax for PAP-related purposes, including as part of PAP audits and to request additional information from me. I authorize the PAP to use My Information for the foregoing purposes, as well as to disclose My Information to auditors of the PAP and to my health plan(s), including Medicare, so that I may receive assistance from PAP if I am eligible. I understand that My Information, once disclosed pursuant to this authorization, may no longer be protected by federal law and could be re-disclosed to others, but I also understand that the PAP intends to use and disclose my Information only for the purposes stated herein. I understand that I do not need to sign this Authorization in order to receive health care treatment or insurance benefits, but that if I do not sign the Authorization, I will not be able to obtain assistance from the PAP. I further understand that I may cancel the Authorization at any time by sending a written notice of cancellation by mail to: Merck Patient Assistance Program, PO Box 690, Horsham, PA 19044. I understand that if I cancel the Authorization, that will not invalidate uses and disclosures of My Information made in reliance on the Authorization before the PAP received notice of my cancellation. If I do not cancel it, the Authorization will remain in effect for 15 months from the date of my signature below (or the maximum period allowed by applicable state law, if less than 15 months). I have read this document or have had it explained to me. I understand that I may request a copy of this Authorization once it has been signed.

SIGN HERE **Patient's Original Signature** _____ **Date** M M D D Y Y Y Y

This form should not be tampered with or revised in any way. Only originals with ink signatures will be accepted.

To report an adverse event to a specific Merck product, including death due to any cause, please contact the Merck National Service Center at 1-800-444-2080.

PHYSICIAN/PRESCRIBER MUST COMPLETE THIS SIDE OF FORM AND SIGN IN ALL PLACES WITH A SIGN HERE
SECTION 4: COMPLETE THE PRESCRIPTION AND PRODUCT INFORMATION BELOW (enter only 1 Merck product per line). PLEASE PRINT IN LEGIBLE CAPITAL LETTERS.

USE A BLACK OR BLUE PEN

THIS IS THE PRESCRIPTION. PLEASE DO NOT SUBMIT A PRESCRIPTION SEPARATE FROM THIS APPLICATION.*

Patient's First Name

Patient's Last Name Date of Birth

Product 1 _____ Strength _____ Quantity _____ Refill _____ (1, 2, or 3) Times

Directions for Use _____

Product 2 _____ Strength _____ Quantity _____ Refill _____ (1, 2, or 3) Times

Directions for Use _____

Product 3 _____ Strength _____ Quantity _____ Refill _____ (1, 2, or 3) Times

Directions for Use _____

SIGN HERE ☐ Dispense As Written: **Physician/Prescriber's Signature** (We cannot accept signature stamps)

ALLERGIES: ☐ None ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Penicillin ☐ Sulfa

Other _____

MEDICAL CONDITIONS: ☐ None ☐ Asthma ☐ Diabetes ☐ Heart ☐ High BP ☐ High Cholesterol

Other _____

PATIENT'S CURRENT MEDICATION(S): _____

***NOTE: ALL CONTROLLED SUBSTANCE PRESCRIPTIONS MUST BE SUBMITTED ELECTRONICALLY (NPI: 1285159152), AND SEPARATELY FROM THIS ENROLLMENT FORM, AND MUST INCLUDE YOUR DEA NUMBER (FOR QUESTIONS CALL: 1-800-727-5400).**

Section 5: Physician/Prescriber Information

Prescriber's First Name M.I.

Prescriber's Last Name Professional Designation

Physician/Prescriber NPI Number

Name of Facility/Site

Mailing Address (PO Boxes not permitted)

Street Address Suite/Bldg/ Floor

City State Zip

Office Phone Ext. Secure Fax

Office Contact Name_____ Email Address _____

Physician/Prescriber Attestation

I certify that this prescription is medically appropriate for this patient and that I will be supervising the patient's treatments. I verify that the information provided is complete and accurate to the best of my knowledge. I authorize the Merck PAP, its affiliated companies, or its subcontractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient. I understand that Merck PAP reserves the right to modify or discontinue this program at this facility/practice, or terminate assistance at any time and without notice. I certify that I will not seek reimbursement or credit for this prescription from any insurer, health plan, or government program. I understand that Merck PAP reserves the right to conduct periodic audits and to request documentation to verify the information provided in this application as it relates to Merck PAP for purposes of determining eligibility of the patient.

SIGN HERE **Physician/Prescriber's Original Signature** **Date** M M D D Y Y Y Y