

### How Can I Submit My Completed Application?



**FAX**

**Januvia and Janumet:** 1-800-419-8371  
**All Other Products:** 1-800-498-5540



**MAIL**

**Merck Patient Assistance Program**  
PO Box 1206, Wilkes Barre, PA 18703-1206



**ONLINE**

Apply online at [www.MerckHelps.com](http://www.MerckHelps.com)

*How Can We Help?*

*For inquiries,  
please call  
1-800-727-5400*

## PROGRAM INFORMATION

As part of our commitment to Patients, the Merck Patient Assistance Program, Inc. (Merck 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 Merck PAP is FREE. Merck PAP is not associated with any individuals or organizations who may charge Patients a fee to assist them in completing enrollment forms for Merck PAP. These individuals or organizations are acting independently of Merck PAP and do not have Merck PAP's consent.

**To be eligible for Merck PAP, both the Patient AND the Prescribing Healthcare Professional must complete, sign, and date this Program application form and certify that:**

1. A Healthcare Provider has prescribed the Patient a Merck medicine covered in the Merck Patient Assistance Program (Merck PAP).
2. The Patient currently resides in the United States (US) or US Territory (the Patient does not need to be a US citizen).
3. The Patient does not have an insurance plan or employer that participates in or is involved in any way with an alternative funding program that requires or encourages you to apply to the Merck Patient Assistance Program as a condition, requirement, or prerequisite for coverage of specific Merck medications. Examples of health insurance include:
  - a. Employer-provided or private insurance
  - b. Health Maintenance Organizations (HMOs)
  - c. Medicaid or Medicare
  - d. Veterans assistance or any other social service agency support
4. The Patient cannot afford to pay for the Merck medicine and Merck PAP can verify the Patient meets the Program's financial eligibility criteria. Information about specific financial criteria levels is available by visiting [MerckHelps.com](http://MerckHelps.com) or calling 1-800-727-5400.
5. For the most current list of Merck medicines available through this Program, please visit [MerckHelps.com](http://MerckHelps.com), or call the Merck Patient Assistance Program at 1-800-727-5400. Patient advocates are available to assist you Monday through Friday, 8 AM to 8 PM ET.

## PROGRAM CHECKLIST

1. Check your eligibility at [MerckHelps.com](http://MerckHelps.com).
2. Both the Patient and the Prescribing Healthcare Professional must complete all sections of this form.
3. Both the Patient and the Prescribing Healthcare Professional must check, sign, AND date this form in all designated places.
4. Once the Patient and Prescriber have completed all sections of the enrollment form, please submit the enrollment form to the Merck Patient Assistance Program. Failure to include all information may result in delayed processing times. Patients and Prescribers will receive a communication once eligibility has been determined.



Scan to learn more about Merck's Patient Assistance Programs or find out more about our online application at [MerckHelps.com](http://MerckHelps.com).

**DO NOT INCLUDE THIS COVER PAGE WHEN FAXING THE COMPLETED AND SIGNED ENROLLMENT FORM.**

### SECTION 1: PATIENT INFORMATION

Patient's First Name     
  Patient's Last Name     
    Date of Birth (MM/DD/YYYY)

Address Line 1     
  Address Line 2 (Apartment/Unit Number)     
 Resident in the US or a US Territory:  Yes  No You do not have to be a US citizen.

City     
  State     
  Zip     
 I Am Enrolling for the First Time:  Yes  No     
 I Am Re-Enrolling:  Yes  No

Provide a phone number and email address so we may contact you with Program notifications and updates:

Mobile Phone     
  Home Phone     
  Email

I would like my product shipped to:

My Home     
  My Physician's Office     
  Other

Other Address

Special Delivery Instructions

Do you have insurance or other prescription drug coverage?  Yes  No

Are you enrolled in any of the following?

Medicare Part A or B     
  Medicare Part D     
  Medicaid     
  Employer-Provided Insurance or Private Insurance

Other  If Other, Please Describe

#### Consent to Process Personal and Sensitive Information for Merck PAP Purposes

If I am eligible to participate, then by consenting below, I agree to enroll in the Merck Patient Assistance Program Inc. (the "Program"). By choosing to enroll, I agree that the Merck Patient Assistance Program and its employees, affiliates, representatives, agents, contractors, and data processors, including the administrators of the Program (collectively, the "Merck PAP"), may collect, use, and disclose personal and sensitive personal information about me, including the details I provided on this form, information about my participation in the Program, and other health information about me, such as my diagnosis, symptoms, medication, and inferences derived from the same, to facilitate my participation in the Program, including, as applicable, to: (i) assess my eligibility to enroll in the Program; (ii) provide me with Merck PAP assistance; (iii) administer the Merck PAP; and (iv) monitor, audit, access, and evaluate the Merck PAP's implementation and effectiveness. I also agree that Merck PAP may contact me via email, text, phone or mail using the contact information I provided on this form for purposes related to the Program, including to send me information about my medication.

I understand that I am not required to consent to the processing of my information. However, if I do not consent, I will not be able to participate in the Program, as the processing of my information is necessary for the Merck PAP to facilitate my participation.

If I consent, I have the right to withdraw my consent at any time by calling 1-800-727-5400, by mailing Merck Patient Assistance Program, PO Box 1206, Wilkes Barre, PA 18703-1206, or via fax at 1-800-419-8371. For more information about Merck's privacy practices and for privacy disclosures applicable to residents of certain US states, see our US Supplemental Privacy Notice at <https://www.msdprivacy.com/us/en/supp-notice/> and our Consumer Health Data Privacy Policy at <https://www.msdprivacy.com/us/en/chd-policy/>.

CHECK  
HERE

I CONSENT to the terms above.

I DO NOT CONSENT to the terms above.

### SECTION 2: PATIENT AUTHORIZATION

#### Patient Authorization for Use and Disclosure of Protected Health Information

By signing below, I authorize each of my healthcare provider(s), pharmacies and health plan(s), including Medicare, to obtain, use, and disclose my protected health information, including the details provided on this form and other health information about me, such as my diagnosis, symptoms, medication, and inferences derived from the same (collectively, "PHI"), to the Merck Patient Assistance Program and its employees, affiliates, representatives, agents, contractors, and data processors, including the administrators of the Program (collectively, the "Merck PAP"), to facilitate my participation in the Program, including for the itemized purposes listed below. I also agree that Merck PAP may obtain, use, and disclose my PHI to my physicians, pharmacies, health plans, my Legal Representatives (if any), and third parties as appropriate to facilitate my participation in the Program, including, to: (i) assess my eligibility to enroll in the Program; (ii) provide me with Merck PAP assistance; (iii) administer the Merck PAP; and (iv) monitor, audit, access, and evaluate the Merck PAP's implementation and effectiveness.

#### By signing this Authorization, I also acknowledge my understanding that:

- The PHI disclosed pursuant to this Authorization, once disclosed, may no longer be governed by certain federal or state privacy laws and may be subject to re-disclosure. However, I also understand that unless I separately consent to additional uses and disclosures, Merck PAP intends to use and disclose my PHI only for the purposes described in this Authorization.
- I do not need to sign this Authorization in order to receive healthcare treatment or insurance benefits, but if I do not sign the Authorization, I will not be able to obtain assistance from the Merck PAP.
- I may cancel this Authorization at any time by mailing a written request to Merck Patient Assistance Program, PO Box 1206, Wilkes Barre, PA 18703-1206, or by calling 1-800-727-5400. I understand that canceling my Authorization will mean that my physicians, pharmacies, and health plans, as well as Merck PAP may no longer rely on this Authorization to disclose my PHI, but that any use or disclosure of such information that occurs before my cancellation is received will be unaffected by my cancellation.
- If I do not cancel this Authorization, the Authorization will expire 15 months from the date of signature (or the maximum period allowed by applicable state law, if less than 15 months). The administrators of the Program will retain the information they have collected about me in accordance with Merck PAP's records retention policy.
- 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.
- I understand that I am entitled to a copy of my signed Authorization and that I can obtain copies by mailing a written request to Merck Patient Assistance Program, PO Box 1206, Wilkes Barre, PA 18703-1206, or by calling 1-800-727-5400.

**SIGN  
HERE**

**By signing, I certify that I have read and agree to the above Patient Authorization for Use and Disclosure of Protected Health Information.**

\_\_\_\_\_  
**Patient's Original Signature**

\_\_\_\_\_  
**Date (MM/DD/YYYY)**

\_\_\_\_\_  
**Legal Representative's Signature\***

\_\_\_\_\_  
**Date (MM/DD/YYYY)**

\_\_\_\_\_  
**If Signed by a Legal Representative, Please Describe Your Authority to Act on Behalf of the Patient**

\_\_\_\_\_  
**Name of Signing Party (Please Print)**

\_\_\_\_\_  
**Phone Number of Legal Representative**

#### DECLARATION OF LEGAL REPRESENTATIVE

I declare that I am the Legal Representative of the Patient and that I have the legal authority under applicable state law to bind the Patient by signing each Authorization or Declaration in this enrollment form.

*\*A Legal Representative is a person who has legal authority under applicable law to bind you (the Patient) by signing each Authorization or Declaration in this enrollment form.*

\_\_\_\_\_  
Patient's First Name

\_\_\_\_\_  
Patient's Last Name

### SECTION 3: INCOME VERIFICATION

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: \_\_\_\_\_

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

**Option 1:** 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
- Social Security Benefits Letter
- Disability Statement
- One month of pay stubs, prior to the application date
- Veteran Benefits Statement
- Pension Letter
- Unemployment Benefits Statement
- Income Verification Letter from an employer

OR

**Option 2:** Authorizing Merck PAP and other individuals involved in administering the Merck 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.

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**

**Patients should only sign this section if they are selecting Option 2.**

\_\_\_\_\_  
Patient's Original Signature

\_\_\_\_\_  
Date (MM/DD/YYYY)

\_\_\_\_\_  
Legal Representative's Signature\*

\_\_\_\_\_  
Date (MM/DD/YYYY)

\_\_\_\_\_  
**If Signed by a Legal Representative, Please Describe Your Authority to Act on Behalf of the Patient**

#### 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 (Merck 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 4, 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 4 of this application form. I understand that assistance received through the Merck PAP is not insurance.

**SIGN  
HERE**

\_\_\_\_\_  
Patient's Original Signature

\_\_\_\_\_  
Date (MM/DD/YYYY)

\_\_\_\_\_  
Legal Representative's Signature\*

\_\_\_\_\_  
Date (MM/DD/YYYY)

\_\_\_\_\_  
**If Signed by a Legal Representative, Please Describe Your Authority to Act on Behalf of the Patient**

\*A Legal Representative is a person who has legal authority under applicable law to bind you (the Patient) by signing each Authorization or Declaration in this enrollment form.

### SECTION 4: PRESCRIPTION INFORMATION

Complete the prescription and product information below (enter only one Merck product per line). 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 (MM/DD/YYYY)	
Product/Strength 1	Directions for Use	Quantity	Refill (1, 2, or 3 Times)
Product/Strength 2	Directions for Use	Quantity	Refill (1, 2, or 3 Times)
<b>ALLERGIES:</b> <input type="checkbox"/> No Known Drug Allergies <input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine <input type="checkbox"/> Iodine <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other <input type="text"/> Other Allergies			
<b>MEDICAL CONDITIONS:</b> <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart <input type="checkbox"/> High BP <input type="checkbox"/> High Cholesterol <input type="text"/> Other Medical Conditions			
Patient's Current Medication(s) Including OTC			

**SIGN HERE**

\_\_\_\_\_  
Prescriber's Signature

*(We cannot accept signature stamps.)*

Dispense as Written

\*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: PRESCRIBER INFORMATION

Prescriber's First Name	M.I.	Prescriber's Last Name	Prescriber's NPI Number	
Name of Facility/Site		Address Line 1 (PO Boxes Not Permitted)		
Address Line 2 (Suite/Building/Floor)	City	State	Zip	Office Phone Number
Fax	Office Contact Name		Email	

**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 of the records of all entities receiving product in connection with Merck PAP or 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. I accept that reasonable notice will be granted and audits will be conducted during regular business hours. I understand Merck PAP may suspend facility from utilization of the Program to new enrollees, at Merck PAP's discretion, without advance notice, if the facility does not commit to an audit (scheduling and completion). I represent and warrant that this facility has obtained all applicable authorizations, consents, and notices necessary to comply with all federal and state laws and regulations relating in any way to medical and/or health privacy including but not limited to the HIPAA Privacy Rule, codified at 45 C.F.R. Parts 160 and 164, as amended from time to time.

**SIGN HERE**

\_\_\_\_\_  
Prescriber's Signature

*(We cannot accept signature stamps.)*

\_\_\_\_\_  
Date (MM/DD/YYYY)