PO Box 690
Horsham, PA
19044-9979

MERCK PATIENT ASSISTANCE PROGRAM ENROLLMENT FORM

For inquiries, please call
800-727-5400

PATIENT MUST COMPLETE THIS SIDE.

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

Use a Black or Blue Pen

Patient's First Name _____ M.I. _____ US Resident* Yes ☐ No ☐

Last Name _____

Address _____ Apt. No. _____

City _____ State _____ ZIP _____

Phone _____ Date of Birth _____ (M M D D Y Y Y Y) Gender: Male ☐ Female ☐

Provide an e-mail address if you would like to be notified with an acknowledgement of enrollment form receipt _____

List current annual gross household income below. Indicate the source(s) of your income by checking all boxes that apply.

Total Annual Income $ _____ No. of Household Members (including patient) _____

Social Security Benefits (SS, SSI, SSDI) ☐ Wages ☐

Interest/Dividends ☐ Pension ☐ Unemployment Compensation ☐

Please list other income source(s) _____

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

Do you have **prescription** coverage? Yes ☐ No ☐

If yes, please check all boxes that apply.

Medicare ☐ Medicaid ☐ State Pharmacy ☐

Employer ☐ Medicare Part D ☐ Private Policy ☐

Other (e.g. Medicare Supplement) ☐

If other, please complete _____

Insurance Carrier _____ Phone No. _____

Policy ID _____ Group No. _____

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 PAP reserves the right to modify the application form, modify or discontinue this program, or terminate assistance at any time and without notice. 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.

SIGN Patient's Original Signature _____ Date _____ (M M D D Y Y Y Y)

Applicant Authorization for Use and Disclosure of Personal Health Information

I understand that in order for the Merck Patient Assistance Program, Inc. (Merck PAP) to provide me with assistance, it will need to obtain, review, use, and disclose my personal health information (PHI), including information relating to my medical condition and information on my application form. I agree to allow the Merck PAP Program to contact me via mail, telephone or email to carry out these services. I authorize my physician, pharmacy, and my health plan(s) to disclose my PHI to Merck PAP and its administrators as necessary to complete the Merck PAP application process or to verify my application. I understand that my name, address, and any other personal identifying information provided in my application will be available to Merck PAP and its affiliates. I understand that my PHI disclosed under this application may no longer be protected by privacy laws and may be re-disclosed by Merck PAP only for the purposes described here. I understand that I if I don't provide this Authorization, I won't be able to obtain assistance from Merck PAP. I understand that I may cancel this Authorization at any time by mailing a written request for such cancellation to my prescribing physician and Merck PAP, and the cancellation will not apply to any information already used or disclosed pursuant to this Authorization. If I do not cancel this Authorization, the Authorization will expire 15 months from the date signed below. I also understand that information concerning program participants may be summarized for statistical or other purposes and provided to Merck PAP, but that any such summary shall be of de-identified data and shall not disclose, nor be able to be used to disclose, my identity. 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 Patient's Original Signature _____ Date _____ (M M D D Y Y Y Y)

*You do not have to be a US citizen.

Physician must complete Sections 2 and 3 on the back of this form.

Merckhelps.com

PHYSICIAN/PRESCRIBER MUST COMPLETE THIS SIDE.

SECTION 2: COMPLETE THE PRESCRIPTION AND PRODUCT INFORMATION BELOW. 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 M.I.

Last Name

Date of Birth M M D D Y Y Y Y

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

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

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

Physician/Prescriber State License Number _____ Date _____

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

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

MEDICAL CONDITIONS: ☐ None ☐ Asthma ☐ Glaucoma ☐ Heart ☐ High BP ☐ Ulcer Other _____

CURRENT MEDICATION(S) BEING TAKEN BY THE PATIENT: _____

SECTION 3: PHYSICIAN/PRESCRIBER MUST COMPLETE, SIGN AND DATE.

Physician's First Name M.I.

Physician's Last Name

Professional Designation

Name of Facililty/Site

Mailing Address (PO Boxes not permitted)

Street Address 1

Street Address 2

City State ZIP

Office Phone - - Ext.

Secure Fax - -

Office Contact Name _____ E-mail 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.

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

This form should not be tampered with or revised in anyway. 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.