MERCK PATIENT ASSISTANCE PROGRAM ENROLLMENT FORM

Send completed and SIGNED forms to: Merck Patient Assistance Program, PO Box 690, Horsham, PA 19044-9979

For inquiries, please call 800-727-5400

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

Use a Black or Blue Pen

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

Patient's First Name

US Resident* Yes No

*You do not have to be a US citizen

Last Name

Address

Apt. No.

City

State

ZIP

Phone

Date of Birth M M D D Y Y Y Y

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.
(Your income before taxes)

Total Annual Income $

Number of Household Members (including patient)

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

☐ Medicare ☐ Medicaid ☐ Medicare Part D ☐ Other

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

☐ Other Address: ____________________

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 **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, 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 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 **Patient's Original Signature** ____________________ **Date** M M D D Y Y Y Y

PHYSICIAN/PRESCRIBER MUST COMPLETE THIS SIDE OF FORM AND SIGN IN BOTH PLACES WITH A SIGN

SECTION 2: COMPLETE THE PRESCRIPTION AND PRODUCT INFORMATION BELOW.
PLEASE PRINT IN LEGIBLE CAPITAL LETTERS (enter only 1 Merck product per line).

Use a Black or Blue Pen

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

Patient's First Name

Last Name

Date of Birth M M D D Y Y Y Y

Product 1 Isentress Strength 400 MG Quantity 60 Directions Take 1 Pill Twice a Day Refill 0 (1, 2, or 3) Times

Product 2 ______ Strength ______ Quantity ______ Directions ______ Refill ____ (1, 2, or 3) Times

Product 3 ______ Strength ______ Quantity ______ Directions ______ Refill ____ (1, 2, or 3) Times

Product 4 ______ Strength ______ Quantity ______ Directions ______ Refill ____ (1, 2, or 3) Times

Product 5 ______ Strength ______ Quantity ______ Directions ______ Refill ____ (1, 2, or 3) Times

Physician/Prescriber State License Number ______ Expiration Date of License: ______

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: ______

***NOTE: ALL CONTROLLED SUBSTANCE PRESCRIPTIONS MUST BE WRITTEN SEPARATELY FROM THE ENROLLMENT FORM.**

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

Physician's First Name M.I.

Physician's Last Name

Professional Designation

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 **Physician/Prescriber'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.

Copyright © 2020 Merck Sharp & Dohme Corp., a subsidiary of **Merck & Co., Inc.** All rights reserved US-NON-06566 11/20