AccessSIVEXTRO™ Enrollment Form

PHONE: 1-844-282-4782 **FAX:** 1-844-282-4783
ALT PHONE: 1-407-888-5304 **FAX:** 1-407-888-5305

INSTRUCTIONS FOR COMPLETING THIS FORM

Services Requested – REQUIRED

- Choose the Services that are being requested

Patient Information – REQUIRED

- Include the patient's contact information
- Ensure the patient signs and dates the form

Health Care Professional Information – REQUIRED

- Ensure the prescriber signs and dates the form

Insurance Information – REQUIRED

- Fill out this section for all forms of insurance coverage and fax copies (front and back) of the patient's medical and pharmacy insurance card(s)

Patient Financial Information – (Complete if Patient Assistance Program ["PAP"] assistance is requested)

- Specify household income sources and number of individuals in the household
- Include a copy of the prescription

All forms must be submitted together (Health Care Professional and Patient) – REQUIRED

- If you would like the option to have AccessSIVEXTRO™ assist, if needed, with getting the prescription filled, please include a copy of the prescription
- If Co-pay Assistance (eligible privately insured patients) or PAP assistance (eligible uninsured patients) is being requested, please include a copy of the prescription

AINF-1152249-0006 09/15

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Reset Form

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1. SERVICES REQUESTED

☐ Patient Benefits Investigation, Prior Authorization, or Appeal

☐ Co-pay Assistance (Please include a copy of the prescription with this form)

☐ Referrals to the Patient Assistance Program ("PAP") (Please include a copy of the prescription with this form)

2. PATIENT INFORMATION

Name _____ Gender: ☐ Male ☐ Female Date of Birth ____ / ____ / ____

Address _____ City _____ State _____ ZIP _____

Email _____ Home Phone _____ Cell Phone _____

Work Phone_____ Alternate Contact Person (Optional)_____ Alternate Phone Number (Optional)_____

3. HEALTH CARE PROFESSIONAL INFORMATION (REQUIRED)

Physician Name _____

Physician NPI _____ Physician State License # _____ Physician Tax ID _____

Address _____ City _____ State _____ ZIP _____

Practice/Facility Name _____

Office Contact Person _____ Office Contact Phone _____ Office Contact Fax _____

Diagnosis Code _____

4. INSURANCE INFORMATION – PLEASE INCLUDE A COPY OF THE FRONT & BACK OF INSURANCE CARD(S)

☐ Patient is insured (Please fill out all of the applicable insurance information below.)

☐ Patient is uninsured (No health insurance through any public or private payer.)

Primary Insurer (including Medicaid, Medicare, veterans benefits, and private insurers)

Plan Name and State _____

Phone Number for Customer Service _____

Name of Policyholder _____ Policyholder Date of Birth ____ / ____ / ____

Policyholder Relation to Patient _____ Group No. _____

Policy ID No. _____

Secondary/Supplemental Insurer

Plan Name and State _____

Phone Number for Customer Service _____

Name of Policyholder _____ Policyholder Date of Birth ____ / ____ / ____

Policyholder Relation to Patient _____ Group No. _____

Policy ID No. _____

5. PATIENT FINANCIAL INFORMATION (COMPLETE IF PAP ASSISTANCE IS REQUESTED)

Current Annual Gross Household Income $ _____ Number in Household _____

*Please include: before-tax wages, pension, interest/dividends, Social Security benefits, and any other sources of income

To report an adverse experience with a specific Merck medicine, please call the Merck National Service Center at 1-800-444-2080.

AINF-1152249-0006 09/15

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HEALTH CARE PROVIDER DECLARATION

MUST CONTAIN ORIGINAL SIGNATURE

By signing below, I represent and warrant the following:

- This request has been prepared exclusively by the physician or physician office identified in this request ("my Practice").
- My Practice has obtained written authorization from the patient identified in this request to disclose the patient's personal health information (PHI), including information relating to the patient's medical condition and prescription medications and the information disclosed in this patient enrollment form, to The AccessSIVEXTRO™ program sponsored by Merck Sharp & Dohme Corp. ("Merck"), a subsidiary of Merck & Co., Inc., or the Merck Patient Assistance Program ("PAP") sponsored by the Merck Patient Assistance Program, Inc. ("Foundation"), (individually, "a Program"; collectively, "the Programs"), the administrators of the Programs, including their contractors or other affiliates, for the Programs to use and disclose the information for the purposes of benefits investigation, reimbursement support, and referrals to the PAP.
- My Practice has provided the patient identified in this request with the notices necessary to comply with all federal and state laws and regulations relating 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.
- I certify that I, or a physician in my Practice, have determined that the patient is a part of the population for which the product is indicated and I certify that this product is medically indicated for this patient, and that I, or a physician in my Practice, will be supervising the patient's treatment.
- If the patient receives product through the PAP, reimbursement for such product will not be sought from any source.
- I also understand that neither I nor my Practice will receive any reimbursement from Merck.
- I understand that information concerning program participants may be summarized for statistical or other purposes and provided to Merck and/or the Programs.
- I verify that the information provided in this Enrollment Form is complete and accurate to the best of my knowledge.
- I understand that the Program reserves the right to conduct periodic audits of the records, excluding patient-identifiable data (unless the auditor enters into an appropriate relationship with the facility to protect an individual's medical privacy).

PHYSICIAN'S ORIGINAL SIGNATURE: _____ **DATE:** _____

PHYSICIAN'S NAME (PLEASE PRINT): _____ **LICENSE NO.:** _____

AINF-1152249-0006 09/15

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APPLICANT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

- I understand that before I may have communications with The AccessSIVEXTRO™ Program, sponsored by Merck Sharp & Dohme Corp. ("Merck"), or receive assistance from the Merck Patient Assistance Program ("PAP"), sponsored by the Merck Patient Assistance Program, Inc. ("Foundation") (individually, "a Program"; collectively, "the Programs"), the administrators of the Programs, including their contractors or other representatives, will need to obtain, review, use, and disclose my personal health information ("PHI"), including information relating to my medical condition and prescription medications and the information disclosed in this patient enrollment form.
- I therefore authorize each of my physicians, pharmacies, and health plans to disclose my PHI, as necessary, to the administrators of the Programs and their contractors or representatives (eg, auditors), in order to verify my eligibility to enroll in the Programs and to enroll me in the Programs for which I am eligible.
- I also authorize the administrators of the Programs and their contractors or representatives to use my PHI to provide the services described in this enrollment form, and to disclose my PHI to my physicians and pharmacists as well as to Medicare, when applicable, my health plans, and their administrators, contractors, or representatives, in order for them to coordinate my benefits, provide reimbursement support, investigate my insurance coverage, and/or refer my application to the PAP.
- I also authorize the administrators of the Programs and their contractors and representatives to use my PHI to communicate with me by U.S. postal mail, telephone, or e-mail to carry out the services described in this enrollment form.
- I understand that information concerning program participants may be summarized for statistical or other purposes and provided to the Program.
- I understand that the PHI disclosed pursuant to this authorization, once disclosed, may not be governed by federal privacy law and may be subject to re-disclosure, but I also understand that the administrators of the Programs and their contractors and other representatives intend to use and disclose my PHI only for the purposes described in this authorization. I further understand that if I choose not to provide this authorization, it will not affect my eligibility for, or receipt of, treatment, including Merck products, or health care insurance benefits, but that I will not be able to receive any assistance from the Programs for which I may be eligible.
- I understand that I may cancel this authorization at any time by telephoning The AccessSIVEXTRO™ Program at (844) 282-4782 or by mailing a written request for cancellation to AccessSIVEXTRO™, 6251 Chancellor Drive Suite 101 Orlando, Florida 32809. I understand that canceling my authorization will mean that my physicians, pharmacies, and health plans may no longer rely on the authorization to share my PHI with the Programs, and that the Programs, their administrators, and their contractors and representatives will not be authorized to use or disclose the information pursuant to this authorization after my cancellation is received, but that any use or disclosure of such information that occurs before my cancellation is received will be unaffected by my cancellation.
- I understand that if I do not cancel this authorization, the authorization will expire 15 months from the date noted below. The administrators of the Programs will retain the information I have submitted in accordance with Merck's records retention policy. I understand that I am entitled to receive a copy of this authorization once it has been signed.
- I understand it is my responsibility to inform the Program of any circumstances as it relates to a change in my Household income or my insurance.
- I have read this authorization or have had it explained to me.

SIGNATURE OF PATIENT: _____

NAME OF PATIENT (PLEASE PRINT): _____

DATE: _____

AINF-1152249-0006 09/15

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CO-PAY ASSISTANCE PROGRAM TERMS AND CONDITIONS

THE CO-PAY ASSISTANCE PROGRAM IS NOT INSURANCE.

- To receive benefits under the Co-pay Assistance Program for SIVEXTRO® (tedizolid phosphate) 200 mg tablet ("Program Product"), the patient must enroll in the Co-pay Assistance Program and be accepted as eligible. The Co-pay Assistance Program is not valid for SIVEXTRO® (tedizolid phosphate) for injection, for intravenous use.
- Patient must be prescribed the Program Product for an FDA-approved indication.
- Patient must be 18 years of age or older and must have private health insurance. Program Product must be purchased by the patient at an eligible retail or mail order pharmacy.
- **The Co-pay Assistance Program is not valid for patients covered under Medicaid, Medicare, a Medicare Part D or Medicare Advantage plan (regardless of whether a specific prescription is covered), TRICARE, CHAMPUS, Puerto Rico Government Health Insurance Plan ("Healthcare Reform"), or any other state or federal medical or pharmaceutical benefit program or pharmaceutical assistance program (collectively, "Government Programs"). The Co-pay Assistance Program is not valid for uninsured patients.**
- **The Co-pay Assistance Program is not valid for patients covered under any qualified health plan purchased through a health insurance exchange (marketplace) established by a state government or the federal government ("Exchange Plan").**
- Patient must have an out-of-pocket cost for the Program Product and purchase the Program Product prior to the expiration date of the Co-pay Assistance Program. **Patient must pay the first $15 of co-pay on a prescription for up to 6 tablets of Program Product.** The benefit available under the Co-pay Assistance Program is limited to the patient's actual out-of-pocket cost over $15, for up to 6 tablets of the Program Product, up to a maximum total benefit of $1500. The benefit available under the Co-pay Assistance Program is valid for the patient's out-of-pocket cost for the Program Product only. It is not valid for any other out-of-pocket costs (for example, office visit charges or medication administration charges) even if such costs are associated with the administration of the Program Product.
- Patient, pharmacist, and prescriber agree not to seek reimbursement for all or any part of the benefit received by the patient through the Co-pay Assistance Program. Patient is responsible for reporting receipt of Co-pay Assistance Program coupon benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Co-pay Assistance Program, as may be required.
- Co-pay Assistance Program coupon can be redeemed only by eligible residents of the United States or the Commonwealth of Puerto Rico at eligible retail or mail-order pharmacies in the United States or the Commonwealth of Puerto Rico. Product must originate in the United States or the Commonwealth of Puerto Rico.
- Co-pay Assistance Program benefits are not available for patient costs incurred prior to the date the patient is determined to be eligible under and enrolled in the Co-pay Assistance Program. Patients who are determined to be eligible for benefits under the Co-pay Assistance Program for a prescription for a Program Product must reenroll and be reapproved for any subsequent prescription.
- All information applicable to the Co-pay Assistance Program requested on the enrollment form must be provided, and all certifications must be signed. Forms that are modified or do not contain all the necessary information will not be eligible for benefits under the Co-pay Assistance Program.
- No other purchase is necessary.
- **The Co-pay Assistance Program is not insurance.**
- The Co-pay Assistance Program forms may not be sold, purchased, traded, or counterfeited. Void if reproduced.
- The Co-pay Assistance Program is void where prohibited by law, taxed, or restricted. The Co-pay Assistance Program is not transferable. No substitutions are permitted.
- The Co-pay Assistance Program benefit cannot be combined with any other Co-pay Assistance Program, free trial, discount, prescription savings card, or other offer.
- Merck Sharp & Dohme Corp. reserves the right to rescind, revoke, or amend the Co-pay Assistance Program at any time without notice. Co-pay Assistance Program form is the property of Merck and must be turned in on request.
- Data related to patient's receipt of Co-pay Assistance Program benefits may be collected, analyzed, and shared with Merck, for market research and other purposes related to assessing Co-pay Assistance Programs. Data shared with Merck, will be aggregated and de-identified, meaning it will be combined with data related to other Co-pay Assistance Program redemptions and will not identify patient.

EXPIRATION DATE: 01/31/2016.

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CO-PAY ASSISTANCE PROGRAM PATIENT CERTIFICATION

I certify that I have read and understand the Terms and Conditions of the Co-pay Assistance Program. I certify that I meet the eligibility requirements listed in the Terms and Conditions and that the information I am providing on this form is true and correct.

I certify that I have private insurance and that no part of the costs associated with the Program Product for which I am seeking a benefit under the Co-pay Assistance Program was or will be covered or reimbursed by a Government Program or Exchange Plan, as those terms are defined in the Co-pay Assistance Program Terms and Conditions. I understand that if I begin to have coverage under any Government Program or Exchange Plan or if my state prohibits the redemption of manufacturer Co-pay Assistance (coupons) at any time, I will no longer be eligible to receive benefits under the Co-pay Assistance Program.

I certify that my insurance company has not prohibited the redemption of manufacturer Co-pay Assistance (coupons) for the Program Product and I understand that if at any time my insurance company prohibits the redemption of manufacturer Co-pay Assistance (coupons) for the Program Product, I will no longer be eligible to receive benefits under the Co-pay Assistance Program.

I understand that I am responsible for reporting receipt of Co-pay Assistance Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Co-pay Assistance Program, as may be required.

I agree not to seek reimbursement for all or any part of the benefit I receive through the Co-pay Assistance Program.

I understand that if I am eligible, the Co-pay Assistance Program will provide the information needed to process the co-pay assistance directly to the pharmacy filling my prescription for the Program Product. I agree to abide by the Terms and Conditions of the Co-pay Assistance Program.

I will inform the Co-pay Assistance Program immediately in the event I become ineligible to receive benefits under the Program Terms and Conditions or if my insurance changes prior to the time I fill my prescription.

SIGNATURE OF PATIENT: _____

NAME OF PATIENT (PLEASE PRINT): _____

DATE: _____

AINF-1152249-0006 09/15

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CO-PAY ASSISTANCE PROGRAM PHYSICIAN CERTIFICATION

I, a licensed health care professional, certify that I have prescribed the Program Product to the patient indicated on this form in the exercise of my independent medical judgment for an FDA-approved indication. I have read and agree to the Terms and Conditions of the Co-pay Assistance Program. I certify that, to the best of my knowledge, the patient meets the criteria set forth in the Terms and Conditions, and that the information I am providing on this form is true and correct.

I certify that I will not take into account the fact that the patient may receive a benefit from the Co-pay Assistance Program when determining the amount of any charge(s) to the patient. I certify that I will not charge the patient any fee to complete this form and I will not advertise or otherwise use the Co-pay Assistance Program as means of promoting my services or the Program Product.

I certify that I will not seek reimbursement for all or any part of the benefit received by the patient through the Co-pay Assistance Program.

PHYSICIAN'S ORIGINAL SIGNATURE: _____ **DATE:** _____

PHYSICIAN'S NAME (PLEASE PRINT): _____ **LICENSE NO.:** _____

IS PHYSICIAN LICENSED IN VERMONT (Y/N): _____ **IF YES, PROVIDE VERMONT LICENSE NO.:** _____

AINF-1152249-0006 09/15

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The Merck PAP offered through the Merck Patient Assistance Program, Inc.

APPLICANT DECLARATIONS AND AUTHORIZATIONS

- I certify that all of the information provided in this application, including information about household income, is complete and accurate.
- I understand that PAP assistance will terminate if the PAP 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 PAP assistance. 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 the prescription or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs.
- I understand that 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 PAP and its affiliates to forward the prescription to a dispensing pharmacy on my behalf. PAP is not acting as a dispensing pharmacy. PAP is not responsible for verifying any information contained in the prescription forwarded as part of the enrollment process, 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 such information.
- I understand that PAP assistance is not insurance.

SIGNATURE OF PATIENT: _____

NAME OF PATIENT (PLEASE PRINT): _____

DATE: _____

AINF-1152249-0006 09/15

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