AccessCUBICIN™ Enrollment Form

PHONE: 1-844-282-4246 **FAX:** 1-866-428-2478

INSTRUCTIONS FOR COMPLETING THIS FORM

Services Requested – REQUIRED

- Choose the Services that are being Requested

Patient Information – REQUIRED

- Include the primary contact; if other than the patient, include his/her relationship to the patient and his/her preferred phone number
- 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 and number of individuals in the household

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

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

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1. SERVICES REQUESTED

☐ Patient Benefit Investigation

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

Please Note: *If you are requesting replacement of product by the Merck PAP that was administered to an eligible uninsured patient, you must submit the Product Replacement Form available at AccessCubicin.com.*

2. SITE OF SERVICE

☐ Physician Office ☐ Hospital Outpatient (HOPD) ☐ Home Health

☐ Other ____________________

3. 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) ____________

4. 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 ____________________

5. 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. ____________________

6. PATIENT FINANCIAL INFORMATION

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.

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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 AccessCUBICIN™ program sponsored by Merck Sharp & Dohme Corp. ("Merck"), a subsidiary of Merck & Co., Inc., or the 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.
- 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.:** ______________

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APPLICANT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

- I understand that before I may have communications with The AccessCUBICIN™ Program, sponsored by Merck Sharp & Dohme Corp. ("Merck"), or receive assistance from the 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 Merck and/or the Programs.
- 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 AccessCUBICIN™ Program at (844) 282-4782 or by mailing a written request for cancellation to AccessCUBICIN™, 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: ______________________________

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THE MERCK PATIENT ASSISTANCE PROGRAM

APPLICANT DECLARATIONS AND AUTHORIZATIONS

- I certify that all of the information provided in this application, including information about household income, is complete and accurate and that without enrollment in the Merck PAP I would not be able to afford this medication.
- I understand that PAP assistance will terminate if the PAP becomes aware of any fraud or if this medication is no longer indicated 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 understand that PAP assistance is not insurance.

SIGNATURE OF PATIENT: ______________________________

NAME OF PATIENT (PLEASE PRINT): ______________________________

DATE: ______________________________

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