CUBICIN® (daptomycin for injection) Patient Assistance Program

ADDRESS: P.O. Box 4280, Gaithersburg, MD 20897-8500
PHONE: 844-282-4246 **FAX:** 866-428-2478

The Patient Assistance Program ("PAP") is a replacement program. Product may only be replaced after the patient's treatment has ended and is based on the final dosing and vial usage information provided on this form. Do not return this form until the conclusion of the patient's treatment. A completed AccessCUBICIN™ Enrollment Form is also required to be submitted if one has not already been submitted. Please ensure that both the patient and physician have signed the Enrollment Form, including all sections necessary for the PAP.

Product replacement may be available for patients who do not have insurance and who meet certain financial and medical criteria.

A separate form must be completed for each Dispensing Facility that dispensed product to the patient.

To be completed by healthcare providers.

PHYSICIAN INFORMATION

Physician Name ______________________________

Physician License No. ____________ Physician Tax ID No. ____________ Physician NPI No. ____________

DISPENSING FACILITY

Facility Name ______________________________

Ship to Address (No PO Boxes) ______________________________

City ____________ State ______ Zip Code ____________

(Please provide a street address only, no PO boxes. Replacement product will be shipped to this facility address.)

Phone ____________ Fax ____________

PATIENT INFORMATION

Patient Name ____________ Date of Birth ____ / ____ / ____

Place of Administration/Facility Name ____________ Office Contact ____________

Address ______________________________

City ____________ State ______ Zip Code ____________

Phone ____________ Fax ____________

DESIRED DELIVERY TIMES

Please indicate the preferred times and days of the week for delivery of the shipment of CUBICIN to your facility:

Shipping Contact Person (Other than physician) ______________________________

Days of the Week: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday Times ____________

PRESCRIBING INFORMATION

Medication	Dose	Number of Vials	Frequency of Administration	Dates of Service	
				Start Date	End Date
CUBICIN	________ mg	________	________	________	________

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HEALTH CARE PROVIDER DECLARATION

HEALTH CARE PROVIDER NAME ______________________________

I have prescribed CUBICIN for the above patient. My patient has consented to my providing you this information.

I confirm that the above patient received CUBICIN as prescribed in the Prescribing Information section of this form.

I verify that the information provided on this application is complete and accurate. I understand that the patient must meet certain medical and financial criteria to be eligible for assistance. The replacement product for the product administered to the above patient will be considered a donation to the patient from the Patient Assistance Program. I also understand that the product I receive is not a sample, but a replacement of product I previously purchased. I understand that I will not receive any reimbursement from Merck, whether for administration fees or otherwise. Reimbursement for the cost of the product administered to the above patient on the date(s) indicated has not been sought and will not be sought from any source. Acceptance of this replacement product in no way obligates my facility to use the selected product for other patients. Additionally, I understand that Merck reserves the right to conduct periodic audits of the records, excluding patient-identifiable data (unless the auditor enters into an appropriate agreement with the facility to protect an individual's medical privacy), of all entities receiving product replacement. I accept that reasonable notice will be granted and audits will be conducted during regular business hours. 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. I understand that the PAP reserves the right to modify or revoke this program at any time without notice. My signature confirms that this product was provided free of charge to this patient. I verify that, to the best of my knowledge, this information set forth in this application is complete and accurate. I agree to retain a copy of this form in the facility's records and to make it available upon request, as applicable.

Health care provider signature:

PHYSICIAN'S ORIGINAL SIGNATURE ______________________________ **DATE** ______________

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