The ACT Program
PATIENT ENROLLMENT FORM

PO Box 18979
Louisville, KY 40261-0979

Fax completed form to the ACT Program: 866-363-6389
For inquiries please call 866-363-6379

Please use this form to request reimbursement support and/or to have the patient referred to the patient assistance program.

Support requested (check all that apply)

- ☐ **Patient Benefit Investigation**
- ☐ **Referral to Patient Assistance Program**

PATIENT INFORMATION

Patient name: _____ Date of birth: _____ MM/DD/YYYY

Address: _____ ☐ Male ☐ Female

(Please provide a street address only, no PO boxes)

City/State/Zip: _____

Phone (home): _____ (work): _____ (other): _____

Preferred language if other than English: _____

DECLARATION OF LEGAL REPRESENTATIVE (to be completed by legal representative)

I declare that I am the legal representative of the patient and that I have the legal authority under applicable state law to bind the patient by signing each authorization or declaration in this enrollment form.

Name of Legal Representative: _____

Legal Representative's Original Signature: _____

Relationship of Legal Representative to Patient : _____

Date: _____

DESIGNATION OF PERSONAL REPRESENTATIVE (to be completed by patient or legal representative)

You or your legal representative may designate a personal representative who can act on your behalf to verify the information that you provide in this form and/or coordinate the provision of benefits available to you under the selected programs for which you are eligible.

Name of Personal Representative:

Phone (home): _____ (cell): _____ (work): _____ (text): _____

Mailing Address: _____

E-mail Address: _____

Relationship of Personal Representative to Patient: _____

CONSENT TO ACT AS PATIENT'S PERSONAL REPRESENTATIVE (to be completed by Personal Representative)

I understand that I have been designated as the patient's personal representative for the purpose of communicating with the ACT Program, sponsored by Merck Sharp & Dohme Corp. (“Merck”), a subsidiary of Merck & Co., Inc., or the Merck Patient Assistance Program (the "Merck PAP"), sponsored by the Merck Patient Assistance Program, Inc. (or "Foundation") (individually, “a Program”; collectively, “the Programs”), and their administrator, RxCrossroads, to verify the information provided by the patient in this form and/or to coordinate the provision of benefits available to the patient under the Programs. I authorize the administrators of the Programs to contact me at the mailing address, telephone numbers, e-mail address, and/or text number listed above for that purpose.

Print Name: _____

Signature: _____

Date: _____

Only required for patient assistance program

Current annual gross household income $: _____

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

Number of household members (including patient): _____

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INSURANCE INFORMATION

PLEASE COMPLETE ALL THAT APPLY AND INCLUDE A FRONT AND BACK COPY OF CARD FOR EACH TYPE OF INSURANCE

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: _____

Policy ID No: _____ Group No.: _____

Secondary/supplemental insurer

Plan name and state: _____ Phone number for customer service: _____

Name of policyholder: _____ Policyholder date of birth: _____

Policyholder relation to patient: _____

Policy ID No: _____ Group No.: _____

Prescription/Medicare Part D insurer

Plan name and state: _____ Phone number for customer service: _____

Name of policyholder: _____ Policyholder date of birth: _____

Policyholder relation to patient: _____

Policy ID No: _____ Group No.: _____

Other insurer

Plan name and state: _____ Phone number for customer service: _____

Name of policyholder: _____ Policyholder date of birth: _____

Policyholder relation to patient: _____

Policy ID No: _____ Group No.: _____

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HEALTH CARE PROVIDER TO COMPLETE

PLEASE INCLUDE COPY OF CURRENT PRESCRIPTION(S) WITH COMPLETE DIRECTIONS AND REFILLS FOR *NOXAFIL®* (posaconazole) Delayed-Release Tablets.

Physician practice name: _____

Physician name: _____

Physician Tax No.: _____ Physician NPI No: _____ Physician License No: _____

Physician DEA No.: _____

Address: _____
(Please provide a street address only, no PO boxes.)

City/State/Zip: _____

Phone: _____ Fax: _____

Office contact person: _____ Office contact number: _____

Practice/Facility name: _____

Practice/Facility address: _____

City/State/Zip: _____

Practice tax ID No. : _____ Practice NPI No. : _____ Practice DEA No.: _____

HEALTH CARE PROVIDER SIGNATURE AND 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 ACT Program, sponsored by Merck Sharp & Dohme Corp. ("Merck"), a subsidiary of Merck & Co., Inc., or the Merck Patient Assistance Program, Inc., (individually, "a Program"; collectively, "the Programs"), the administrator of the Programs, RxCrossroads, including their contractors or other affiliates, for the Programs to use and disclose the information for the purposes of benefits investigation and reimbursement support.
- 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, has determined that the prescribed product is medically appropriate for the patient identified above and that I, or a physician in my Practice will be supervising the patient's treatment.
- If the patient receives product through the Merck PAP, reimbursement for such product administered to the patient will not be sought from any source.
- I also understand that neither I nor my Practice will receive any reimbursement from Merck, whether for administration fees or otherwise.
- I also understand that information concerning program participants may be summarized for statistical or other purposes and provided to Merck and/or The Programs, but that any such summary shall be of de-identified data and shall not disclose, nor be able to be used to disclose, the patient's identity.
- I verify that the information provided is complete and accurate to the best of my knowledge.

Physician's original signature: _____ Date: _____

Physician's name (please print): _____ License No: _____

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Patient name: _____

APPLICANT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION (to be completed by patient)

I understand that before I may have communications with The ACT Program, sponsored by Merck Sharp & Dohme Corp. ("Merck"), a subsidiary of Merck & Co., Inc., or receive assistance from the Merck Patient Assistance Program, Inc. (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 administrator of the Programs, RxCrossroads, and their contractors or representatives, 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 administrator 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, my health plans, and their administrators, contractors, or representatives, in order for them to coordinate my benefits, provide reimbursement support, and investigate my insurance coverage.

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, 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.

If I have designated a Personal Representative above, I authorize the Programs, their administrators, and their third-party service partners to use my PHI to contact the person I have designated as my Personal Representative for the purpose of verifying the information I have provided in this form and/or coordinating the provision of benefits that may be available to me under the Programs and to disclose my PHI, including information provided in this enrollment form, to my Personal Representative for the purposes described in this paragraph.

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 ACT Program at (866) 363-6379 or by mailing a written request for cancellation to The ACT Program, PO Box 18979, Louisville, KY 40261-0979. 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 have read this authorization or have had it explained to me.

Signature of Patient or Legal Representative: _____

Name of Signing Party (please Print): _____ Date: _____

If legal representative, relationship of legal representative to patient: _____

THE MERCK PATIENT ASSISTANCE PROGRAM
(offered through the Merck Patient Assistance Program, Inc.; to be completed by patient)

I certify that all of the information provided in this application, including information about household income, is complete and accurate.

I understand that Merck PAP assistance will terminate if Merck 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 patient 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 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 the 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 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.

Signature of Patient or Legal Representative: _____

Name of Signing Party (please Print): _____ Date: _____

If legal representative, relationship of legal representative to patient: _____

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.

MERCK

merckhelps.com