The Merck Access Program Enrollment Form

Phone: 855-257-3932, Fax: 855-755-0518
The Merck Access Program
PO Box 29067
Phoenix, AZ 85038

TO GET STARTED, COMPLETE THE ENROLLMENT FORM AND FAX IT TO 855-755-0518.

✔	PLEASE CHECK THE BOX NEXT TO THE PRODUCT PRESCRIBED
☐	EMEND® (aprepitant) capsules 80 mg, 125 mg, for oral use
☐	EMEND® (fosaprepitant dimeglumine) for Injection 150 mg, for intravenous use
☐	INTRON® A (interferon alfa-2b, recombinant) for Injection, 10 million IU, 18 million IU, 50 million IU Please read the Medication Guide for INTRON A, including the information that INTRON A can cause serious side effects that may cause death or may worsen certain serious diseases that you may already have. Please discuss this information with your doctor. In addition, please select and read the Instructions for Use - Powder for Solution (1 mL diluent), Instructions for Use - Powder for Solution (5 mL diluent), and/or Instructions for Use - Solution for Injection. The physician Prescribing Information (1 mL diluent) and Prescribing Information (5 mL diluent) also are available.
☐	SYLATRON™ (peginterferon alfa-2b) for injection for subcutaneous use, 200 mcg, 300 mcg, 600 mcg Please read the Medication Guide for SYLATRON, including the information that SYLATRON can cause serious mental health problems which can lead to suicide. Please discuss this information with your doctor. In addition, please select and read the Instructions for Use (1.25 mL diluent) and/or Instructions for Use (5 mL diluent). The physician Prescribing Information (1.25 mL diluent) and Prescribing Information (5 mL diluent) also are available.

✔	PLEASE SELECT THE PROGRAM(S) YOU WISH TO APPLY TO AND COMPLETE THE CORRESPONDING SECTION(S) OF THE FORM. PLEASE REMEMBER TO SEND THE PRESCRIPTION	
☐	Patient Benefit Investigation	Complete Section 1
	For INTRON A only	Complete Section 1
	☐ Medical Benefit Investigation	Complete Section 1
	☐ Pharmacy Benefit Investigation	Complete Section 1
☐	Prior Authorization	Complete Section 1
☐	Appeal	Complete Section 1
☐	Referral to the Merck Patient Assistance Program (offered through the Merck Patient Assistance Program, Inc.)	
	☐ INTRON A	Complete Sections 1, 2 & 3
	☐ EMEND for Injection	Complete Sections 1, 2 & 3
	☐ EMEND Capsules	Complete Sections 1, 2 & 3
	☐ SYLATRON	Complete Sections 1, 2 & 3
☐	The Merck Co-pay Assistance Program	
	☐ INTRON A	Complete Sections 1, 2 & 4
	☐ SYLATRON	Complete Sections 1, 2 & 5

SECTION 1

PATIENT INFORMATION (to be completed for all patients)

Patient name:_____ Date of birth:_____

Address:_____

(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:_____

Relationship of legal representative to patient:_____

Legal representative's original signature:_____

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 Merck Access 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. (individually, "a Program"; collectively, "the Programs"), and their administrators, McKesson for The Merck Access Program and RxCrossroads for the Merck PAP, 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:_____

INSURANCE INFORMATION (to be completed for all patients)

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 relationship 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 relationship 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 relationship 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 relationship to patient:_____

Policy ID no.:_____ Group no.:_____

SECTION 1 *CONTINUED*

HEALTH CARE PROVIDER INFORMATION (to be completed by health care provider)

Physician name:_____

Physician tax ID no.:_____ Physician NPI no.:_____ Physician license 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 tax ID no.:_____ Practice NPI no.:_____

Practice/Facility address:_____

City/State/Zip:_____

Please list relevant ICD-9 code(s):_____

REGIMEN INFORMATION FOR EMEND® (aprepitant) CAPSULES

Therapeutic regimen:_____

Concomitant medications:_____

HEALTH CARE PROVIDER DECLARATION (to be completed by health care provider)

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 Merck Access 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. (individually, "a Program"; collectively, "the Programs"), the administrators of the Programs, McKesson Specialty Arizona, Inc. ("McKesson") for The Merck Access Program and RxCrossroads for the Merck PAP, including their contractors or other affiliates, including, for McKesson, Covance Market Access ("Covance"), and 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, have 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 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 is complete and accurate to the best of my knowledge.

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.:_____

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.

SECTION 2

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

I understand that before I may have communications with The Merck Access Program, sponsored by Merck Sharp & Dohme Corp. ("Merck"), a subsidiary of Merck & Co., Inc., or receive assistance from the Merck Patient Assistance Program ("PAP"), sponsored by 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 administrators of the Programs, McKesson for The Merck Access Program and RxCrossroads for the Merck PAP, 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 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, and investigate my insurance coverage.

I also authorize my PHI to be disclosed to, and used by, Covance Market Access ("Covance") and its administrators, contractors, representatives, or third-party service partners to provide reimbursement support and to investigate insurance coverage in connection with The Merck Access Program.

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.

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.

(Continues on the next page.)

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

I understand that I may cancel this authorization at any time by telephoning The Merck Access Program at (855) 257-3932 or by mailing a written request for cancellation to The Merck Access Program, PO Box 29067, Phoenix, AZ 85038. 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):_____

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

Date:_____

ONLY REQUIRED FOR THE MERCK PATIENT ASSISTANCE PROGRAM AND THE MERCK CO-PAY 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):_____

SECTION 3

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

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 Merck PAP assistance will terminate if the 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):_____

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

Date:_____

SECTION 4

THE MERCK CO-PAY ASSISTANCE PROGRAM FOR INTRON® A (interferon alfa-2b, recombinant) (to be completed by patient or legal representative)

The Co-pay Assistance Program is not insurance.

The Co-pay Assistance Program for INTRON A consists of two sets of Terms and Conditions, one applicable to INTRON A for which a claim is submitted by a patient's physician ("Medical Benefit") and the other applicable to INTRON A purchased by a patient at a participating pharmacy ("Pharmacy Benefit"). Both sets of Terms and Conditions for the Co-pay Assistance Program for INTRON A are set forth below.

TERMS AND CONDITIONS – INTRON A (MEDICAL BENEFIT)

- To receive benefits under the Co-pay Assistance Program for INTRON A ("Program Product"), the patient must enroll in the Co-pay Assistance Program and be accepted as eligible.
- 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 that provides coverage for the cost of the Program Product under a medical benefit plan. Patient must have a maximum Annual Gross Household Income of less than or equal to 700% of the current Federal Poverty Level.
- **The Co-pay Assistance Program is not valid for patients covered under Medicaid (including Medicaid patients enrolled in a qualified health plan purchased through a health insurance exchange [marketplace] established by a state government or the federal government), 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.**
- Patient must have an out-of-pocket cost for the Program Product and be administered the Program Product prior to the expiration date of the Co-pay Assistance Program. 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. Claim for Program Product must be submitted by physician to patient's private health insurance separately from other services and products.
- **Patient must pay the first $50 of co-pay per administration of Program Product.** The benefit available under the Co-pay Assistance Program is limited to the amount the patient's private health insurance company indicates on the Explanation of Benefits (EOB) that the patient is obligated to pay for the Program Product, less $50, up to an annual maximum of $2,500 per patient, per calendar year (January 1 through December 31).
- An EOB from patient's private health insurance must be submitted within 90 days of the date of the EOB for patient to receive Co-pay Assistance Program benefit; provided, however, that no EOB may be submitted more than 90 days after the expiration date of Co-pay Assistance Program. The EOB must reflect the patient's out-of-pocket cost for the Program Product and submission of the claim by the patient's physician for the cost of the Program Product.
- Patient and physician agree not to seek reimbursement for all or any part of the benefit received by the patient through the Co-pay Assistance Program. Patient and physician are 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.
- Patient must be a resident of the United States or the Commonwealth of Puerto Rico. Product must originate and be administered to patient 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.
- All information applicable to the Co-pay Assistance Program requested on this 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.

(Continues on the next page.)

THE MERCK CO-PAY ASSISTANCE PROGRAM FOR INTRON® A (interferon alfa-2b, recombinant) (CONTINUED) (to be completed by patient or legal representative)

- No other purchase is necessary.
- **The Co-pay Assistance Program is not insurance.**
- The Co-pay Assistance Program form 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. Benefits are not available through these Terms and Conditions for INTRON A purchased by a patient at a pharmacy. Co-pay assistance may be available from Merck for INTRON A purchased by patient at a pharmacy through separate Terms and Conditions, provided, however, that the per patient annual maximum Co-pay Assistance Program benefit for INTRON A across Terms and Conditions is $2,500 per calendar year.
- Merck reserves the right to rescind, revoke, or amend the Co-pay Assistance Program at any time without notice.
- 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.
- These Terms and Conditions are valid for Program Product administered between January 1, 2016, and December 31, 2016.
- **Please read the accompanying Medication Guide and Instructions for Use for INTRON A, including the information that INTRON A can cause serious side effects that may cause death or may worsen certain serious diseases that you may already have. Please discuss this information with your doctor. The physician Prescribing Information also is included.**

Expiration Date: 12/31/2016.

TERMS AND CONDITIONS – INTRON A (PHARMACY BENEFIT)

- To receive benefits under the Co-pay Assistance Program for INTRON A ("Program Product"), the patient must enroll in the Co-pay Assistance Program and be accepted as eligible.
- 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 that provides coverage for the cost of the Program Product purchased by the patient at an eligible participating pharmacy. Patient must have a maximum Annual Gross Household Income of less than or equal to 700% of the current Federal Poverty Level.
- **The Co-pay Assistance Program is not valid for patients covered under Medicaid (including Medicaid patients enrolled in a qualified health plan purchased through a health insurance exchange [marketplace] established by a state government or the federal government), 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.**
- 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 $50 of co-pay on each prescription for Program Product (regardless of quantity supplied on the prescription).** The benefit available under the Co-pay Assistance Program is limited to the amount of the patient's actual out-of-pocket cost over $50, on each prescription, up to a maximum of $2,500 per patient, per calendar year (January 1 through December 31). 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.

(Continues on the next page.)

THE MERCK CO-PAY ASSISTANCE PROGRAM FOR INTRON® A (interferon alfa-2b, recombinant) (CONTINUED) (to be completed by patient or legal representative)

- The Co-pay Assistance Program coupon benefit cannot be combined with any other Co-pay Assistance Program, free trial, discount, prescription savings card, or other offer. Benefits are not available through these Terms and Conditions for INTRON A for which a claim was submitted by a physician to a patient's private health insurance company. Co-pay assistance may be available from Merck for INTRON A for which a claim was submitted by a physician to a patient's private health insurance company through separate Terms and Conditions, provided, however, that the per patient annual maximum Co-pay Assistance Program benefit for INTRON A across Terms and Conditions is $2,500 per calendar year.
- 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 participating 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.
- 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 coupon 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.
- Merck reserves the right to rescind, revoke, or amend the Co-pay Assistance Program at any time without notice. Co-pay Assistance Program coupon 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 Program 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.
- **Please read the accompanying Medication Guide and Instructions for Use for INTRON A, including the information that INTRON A can cause serious side effects that may cause death or may worsen certain serious diseases that you may already have. Please discuss this information with your doctor. The physician Prescribing Information also is included.**

Expiration Date: 12/31/2016

THE MERCK CO-PAY ASSISTANCE PROGRAM FOR INTRON® A (interferon alfa-2b, recombinant) (CONTINUED) (to be completed by patient or legal representative)

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 cost of 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, as that term is defined in the Co-pay Assistance Program Terms and Conditions.

I understand that if I begin to have coverage under any Government Program 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. If I am enrolled in a qualified health plan purchased through a health insurance exchange (marketplace) established by a state government or the federal government (QHP), I understand that if the federal government or my state government prohibits the redemption of manufacturer Co-pay Assistance (coupons) by enrollees in QHPs 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.

MEDICAL BENEFIT ONLY: I understand that my physician/physician's office will submit a claim to my private insurance company for the Program Product administered to me. I authorize my physician/physician's office to submit the Explanation of Benefits received from my private insurance company to the Co-pay Assistance Program and to receive, on my behalf, any benefit for which I am eligible under the Program. I understand that my physician/physician's office will apply any amounts received from the Co-pay Assistance Program toward the satisfaction of my obligation for the cost of the Program Product only. I understand that I am responsible to pay my physician/physician's office $50 per administration of Program Product, and any balance owed to my physician/physician's office not covered by the Co-pay Assistance Program.

I understand that any benefit I am eligible for under the Co-pay Assistance Program will be paid directly to my physician/physician's office, on my behalf, and not directly to me. If I have already paid my physician/physician's office for my share of the cost of the Program Product for which I later receive a benefit through the Co-pay Assistance Program, I will seek the amount, less $50 per administration, back from my physician/physician's office.

I understand that I am free to switch physicians at any time without affecting my eligibility to receive benefits under the Co-pay Assistance Program, provided, however, that my new physician must complete the information required on the form, including the physician certification, before any Co-pay Assistance Program benefit for which I am eligible may be paid to such physician/physician's office on my behalf.

PHARMACY BENEFIT ONLY: I understand that if I am eligible, the Co-pay Assistance Program will mail me a coupon that I can take to an eligible participating retail or mail order pharmacy, along with my prescription, to receive Co-pay Assistance Program benefits.

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 or income changes.

Signature of patient or legal representative:_____

Name of signing party (please print):_____

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

Date:_____

SECTION 4 *CONTINUED*

THE MERCK CO-PAY ASSISTANCE PROGRAM FOR INTRON® A (interferon alfa-2b, recombinant) (CONTINUED) (to be completed by health care provider)

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/my office 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/my office will not charge the patient any fee to complete this form and I/my office 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/my office will not seek reimbursement for all or any part of the benefit received by the patient through the Co-pay Assistance Program.

MEDICAL BENEFIT ONLY: I certify that the claim I submit/my office submits to the patient's private health insurer for payment of the Program Product will have the Program Product listed separately from any claim for medication administration or any other items or services provided to the patient.

I understand that I am/my office is 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 understand that the patient's benefit received under the Co-pay Assistance Program will be paid directly to me/my office by the Co-pay Assistance Program on behalf on my patient. I/my office will apply any amounts received from the Co-pay Assistance Program to the satisfaction of the patient's obligation for the cost of the Program Product only. If I/my office already received payment from the patient for the patient's share of the cost of the Program Product for which the patient receives a benefit through the Copay Assistance Program, I/my office will refund the amounts received (minus $50 per administration) back to the patient.

I understand and agree that the certifications I am providing in this Physician Certification apply to the patient indicated on this form and to any other patient enrolled in the Co-pay Assistance Program who I treat with the Program Product and any claim I submit/my office submits for Co-pay Assistance Program benefits on the patient's behalf. I understand that I may be asked to sign a new Physician Certification if the Terms and Conditions of the Co-pay Assistance Program for the Program Product change.

Physician's original signature:_____ Date:_____

Physician's name (please print):_____ License no.:_____

SECTION 5

THE MERCK CO-PAY ASSISTANCE PROGRAM FOR SYLATRON™ (peginterferon alfa-2b) (to be completed by patient or legal representative)

The Co-pay Assistance Program is not insurance.

TERMS AND CONDITIONS

- To receive benefits under the Co-pay Assistance Program for SYLATRON ("Program Product"), the patient must enroll in the Co-pay Assistance Program and be accepted as eligible.
- 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 that provides coverage for the cost of the Program Product purchased by the patient at an eligible participating pharmacy. Patient must have a maximum Annual Gross Household Income of less than or equal to 700% of the current Federal Poverty Level.
- **The Co-pay Assistance Program is not valid for patients covered under Medicaid (including Medicaid patients enrolled in a qualified health plan purchased through a health insurance exchange [marketplace] established by a state government or the federal government), 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.**
- 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 $50 of co-pay on each prescription for Program Product (regardless of quantity supplied on the prescription).** The benefit available under the Co-pay Assistance Program is limited to the amount of the patient's actual out-of-pocket cost over $50, on each prescription, up to a maximum of $6,000 per patient, per calendar year (January 1 through December 31). 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 required.
- Co-pay Assistance Program Coupon can be redeemed only by eligible residents of the United State or the Commonwealth of Puerto Rico at participating eligible retain 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.
- 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 Programs.

(Continues on the next page.)

THE MERCK CO-PAY ASSISTANCE PROGRAM FOR SYLATRON™ (peginterferon alfa-2b) (CONTINUED) (to be completed by patient or legal representative)

- No other purchase is necessary.
- **The Co-pay Assistance Program is not insurance.**
- The Co-pay Assistance Program coupon 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 transferrable. No substitutions are permitted.
- The Co-pay Assistance Program coupon benefit cannot be combined with any other Co-pay Assistance Program, free trial, discount, prescription savings card, or other offer.
- Merck reserves the right to rescind, revoke, or amend the Co-pay Assistance Program at any time without notice.
- Co-pay assistance Program coupon 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 patients.
- **Please read the accompanying Medication Guide and Instructions for Use for SYLATRON, including the information that SYLATRON can cause serious mental health problems which can lead to suicide, and discuss them with your doctor. The physician Prescribing Information also is included.**

Expiration Date: 12/31/2016

THE MERCK CO-PAY ASSISTANCE PROGRAM FOR SYLATRON™ (peginterferon alfa-2b) (CONTINUED) (to be completed by patient or legal representative)

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 cost of 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, as that term is defined in the Co-pay Assistance Program Terms and Conditions.

I understand that if I begin to have coverage under any Government Program 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. If I am enrolled in a qualified health plan purchased through a health insurance exchange (marketplace) established by a state government or the federal government (QHP), I understand that if the federal government or my state government prohibits the redemption of manufacturer Co-pay Assistance (coupons) by enrollees in QHPs 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 mail me a coupon that I can take to an eligible participating retail or mail order pharmacy, along with my prescription, to receive Co-pay Assistance Program benefits.

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 or income changes.

Signature of patient or legal representative:_____

Name of signing party (please print):_____

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

Date:_____

THE MERCK CO-PAY ASSISTANCE PROGRAM FOR SYLATRON™ (peginterferon alfa-2b) (CONTINUED) (to be completed by health care provider)

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.:_____

MERCK