The Merck Access Program

ENROLLMENT FORM

ZEPATIER™
(elbasvir and grazoprevir)
50 mg/100 mg tablets

P: 866-251-6013 **F:** 800-803-3104
The Merck Access Program, PO Box 29067, Phoenix, AZ 85038

COMPLETE THE APPROPRIATE SECTIONS OF THE ENROLLMENT FORM AND FAX TO 800-803-3104.

1 REQUESTED SERVICE(S) Check all circles that apply

- ◯ Benefits Investigation, Prior Authorization, or Appeal
- ◯ Referral to the Merck Patient Assistance Program (offered through the Merck Patient Assistance Program, Inc.)

2 PATIENT INFORMATION (REQUIRED)

Patient Name:

Street Address (no PO Box):

City/State/Zip:

Phone (Home): (Work/Other):

DOB (mm/dd/yyyy): Gender: ◯ M ◯ F

Resides in US/US Territories: ◯ Yes ◯ No

For Merck Patient Assistance Program only

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):

3 DIAGNOSIS/MEDICAL INFORMATION (REQUIRED) Must be completed by health care provider

Please list all applicable diagnosis code(s):

Genotype: Subtype (if applicable): METAVIR F-score:

Patient Treatment History: ◯ Naïve ◯ Experienced

Actual or anticipated start date (mm/dd/yyyy):

Patient Name:

4 INSURANCE INFORMATION (REQUIRED)

◯ Patient has no insurance

◯ Patient is insured

Please fill out all of the applicable insurance information below and include a front and back copy of insurance card(s).

Primary Insurance: Is this a Medicare Part D plan? ◯ Yes ◯ No

Plan Name: Payer Phone #:

Subscriber Name: Policy Holder Name:

Policy Holder Relationship to Patient: Policy Holder DOB (mm/dd/yyyy):

Policy ID #: Group #:

Secondary Insurance: Is this a Medicare Part D plan? ◯ Yes ◯ No

Plan Name: Payer Phone #:

Subscriber Name: Policy Holder Name:

Policy Holder Relationship to Patient: Policy Holder DOB (mm/dd/yyyy):

Policy ID #: Group #:

5 PATIENT'S PREFERRED PHARMACY To be completed by health care provider

Triage prescription to pharmacy? ◯ Yes ◯ No Pharmacy Type: ◯ Specialty ◯ Retail

Pharmacy Name: Phone #:

Pharmacy Address (retail pharmacies must include street address):

City/State/Zip Code:

Patient Name:

6 PRESCRIBER INFORMATION (REQUIRED) Must be completed by health care provider

Prescriber Name:

Facility Name: Phone #:

Address: City/State/Zip Code:

Office Contact: Phone #:

Fax #: NPI #:

Tax ID #: State License #:

Is the physician licensed in the state of Vermont? ◯ Yes ◯ No

If yes, provide Vermont state license #:

7 PRESCRIPTION INFORMATION
(REQUIRED for the Merck Patient Assistance Program and Requested Prescription Transfer)

Patient Name:

Patient DOB:

City/State/Zip Code:

Prescribing and dispensing laws and regulations vary by state and this form may NOT be consistent with the requirements (eg, content or format) for a valid prescription in your state, in which case you should submit a prescription to the relevant pharmacy (or include such form with this Enrollment Form) in a manner and on a form consistent with the requirements in your state.

Dispense ZEPATIER™ (elbasvir and grazoprevir):

Directions:

Quantity:

Refills:

Allergies/Health Conditions:

Product Substitution Permitted (Signature): Date:

Dispense as Written (Signature): Date:

Patient Name:

Health Care Provider Signature and 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, prescription medications, and the information disclosed in this patient enrollment form, as well as the information included in this request, 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. ("Foundation") (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, 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 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 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):

To report an adverse event to a specific Merck product, including death due to any cause, please contact the Merck National Service Center at 800-444-2080.

Patient Name:

Applicant Declarations and Authorizations

(to be completed by patient)

USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

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. ("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, 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, my health plans, and their administrators, contractors, or representatives, in order for them to coordinate my benefits, provide, when applicable, 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.

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 calling The Merck Access Program at 866-251-6013 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.

Continues on next page

Patient Name:

Applicant Declarations and Authorizations (continued)

(to be completed by patient)

USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION (continued)

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: Date:

Name of Patient (Please Print):

Please note that the signature of the patient is required to conduct a benefit investigation.

Patient Name:

Applicant Declarations and Authorizations (continued)

(to be completed by patient)

THE MERCK PATIENT ASSISTANCE PROGRAM

(offered through the Merck Patient Assistance Program, Inc.)

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

I understand it is my responsibility to promptly inform the Program of any circumstances, as it relates to income or insurance, that change from what is being submitted on this form.

I understand that the Program reserves the right to request documentation to verify the information provided in this application for purposes of determining my eligibility for assistance, including, for example, my income.

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.

I understand that assistance received through the Merck Patient Assistance Program is not insurance.

Signature of Patient: Date:

Name of Patient (Please Print):

If you have questions about completing this form or need additional information, please call **866-251-6013**.

PLEASE FAX THE COMPLETED ENROLLMENT FORM TO 800-803-3104.

MERCK