Important Steps for Patient and Physician/Prescriber:

1. Complete ALL information on the application form.
   You may fill in the fields online and print it.
   OR
   You may print out the form and fill it out by hand using a black ballpoint pen.

2. Take the completed application to your physician/prescriber. **Both the physician/ prescriber and the patient MUST sign the application.**

3. Have your physician/prescriber write your prescription(s) in Section 2 of the application.
   - A single application may include prescriptions for up to **3** Merck medicines.
   - Each prescription may not exceed a 90-day supply at a time, with a maximum of **3 refills**.
   - Each application is valid for up to 12 months; after **12 months** a new application will be required. Under certain circumstances, enrollment may be limited to a calendar year.
   - A separate Merck Patient Assistance Program application is REQUIRED for **each** patient.

4. Mail **completed** applications to:

   Merck Patient Assistance Program
   PO Box 690
   Horsham, PA 19044-9979

Please Note:

- Incomplete or incorrectly completed applications will be returned.
- **Section 2 is your prescription. There is no need to write your prescription on a separate prescription form.**
- Patient's prescription will be sent to the patient's home address unless otherwise requested by the patient/prescriber in Section 1 of the application.
- For additional applications or assistance, please call 1-800-727-5400.

Group: **MERCKRX**

MERCK PATIENT ASSISTANCE PROGRAM APPLICATION

NOTE TO PHYSICIAN: A SEPARATE APPLICATION FORM IS REQUIRED FOR EACH PATIENT.

SECTION 1: COMPLETE THE PATIENT INFORMATION BELOW. PLEASE PRINT (USE BLACK BALLPOINT PEN).

Patient's First Name M.I.

Last Name

Address Apt. No.

City State ZIP

Phone Date of Birth (M M D D Y Y Y Y) Gender: Male Female

Your Social Security No. I Don't Have a Social Security No. No. of Household Members (including patient)

List current annual household income below. Indicate the source(s) of your income by checking all boxes that apply.

Total Annual Income $,

Social Security Benefits (SS, SSI, SSDI) ☐ Wages ☐

Interest/Dividends ☐ Pension ☐ Unemployment Compensation ☐

Please list other source(s) _____

_____

Do you have **prescription** coverage? Yes ☐ No ☐

If yes, please check all boxes that apply.

Medicare ☐ Medicaid ☐ State Pharmacy ☐ Employer ☐

Other (private policy or Medicare Supplement) ☐

If other, please complete. _____

Insurance Carrier _____

Policy ID _____ Group No. _____

Applicant Declarations and Authorization

I certify that all of the information provided in this application, including household income, is complete and accurate. I understand that program assistance will terminate if the program 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 this program. I certify that I cannot afford this medication. 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 this 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 this 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 Section 2, 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 the information contained in Section 2 of this application form.

Patient's Original Signature _____ Date (M M D D Y Y Y Y)

Applicant Authorization for Use and Disclosure of Personal Health Information

I understand that in order for the Merck Patient Assistance Program, Inc. (Merck PAP) to provide me with assistance, it will need to obtain, review, use, and disclose my personal health information (PHI), including information relating to my medical condition and information on my application form. I authorize my physician, pharmacy, and my health plan(s) to disclose my PHI to Merck PAP and its administrators as necessary to complete the Merck PAP application process or to verify my application. I understand that my name, address, and any other personal identifying information provided in my application will be available to Merck PAP and its affiliates. I understand that my PHI disclosed under this application may no longer be protected by privacy laws and may be re-disclosed by Merck PAP only for the purposes described here. I understand that I if I don't provide this Authorization, I won't be able to obtain assistance from Merck PAP. I understand that I may cancel this Authorization at any time by mailing a written request for such cancellation to my prescribing physician and Merck PAP, and the cancellation will not apply to any information already used or disclosed pursuant to this Authorization. If I do not cancel this Authorization, the Authorization will expire 15 months from the date signed below. I have read this document or have had it explained to me. I understand that I may request a copy of this Authorization once it has been signed.

Patient's Original Signature _____ Date (M M D D Y Y Y Y)

Ship Product to: Patient's Home ☐ Physician's Office ☐

Physician must complete Sections 2 and 3 on the back of this form.

SECTION 2: THIS IS THE PRESCRIPTION. PHYSICIAN/PRESCRIBER MUST COMPLETE THE PRESCRIPTION AND PRODUCT INFORMATION BELOW. PLEASE PRINT. (PLEASE DO NOT SUBMIT A PRESCRIPTION SEPARATE FROM THIS APPLICATION.)

Patient's First Name M.I.

Last Name

Date of Birth M M D D Y Y Y Y

Product Name _____ Strength _____ Quantity _____ Directions _____ Refill ___ (1, 2, or 3) Times

Product Name _____ Strength _____ Quantity _____ Directions _____ Refill ___ (1, 2, or 3) Times

Product Name _____ Strength _____ Quantity _____ Directions _____ Refill ___ (1, 2, or 3) Times

Physician/Prescriber State License Number _____ Date _____

☐ Dispense As Written: **Physician/Prescriber's Signature** _____ (We cannot accept signature stamps)

ALLERGIES: ☐ None ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Penicillin ☐ Sulfa Other _____

MEDICAL CONDITIONS: ☐ None ☐ Asthma ☐ Glaucoma ☐ Heart ☐ High BP ☐ Ulcer Other _____

CURRENT MEDICATION(S) BEING TAKEN BY THE PATIENT: _____

SECTION 3: COMPLETE THE PHYSICIAN/PRESCRIBER INFORMATION BELOW AND SIGN THE FOLLOWING STATEMENT.

Physician's First Name M.I.

Last Name

Professional Designation

Site

Address (no PO Box No.)

(Bldg/Suite)

City

State ZIP

Phone - -

Ext.

Secure Fax - -

Physician/Prescriber Attestation

I certify that this prescription is medically appropriate for this patient and that I will be supervising the patient's treatments. I verify that the information provided is complete and accurate to the best of my knowledge. I authorize the Merck PAP, its affiliated companies, or its subcontractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient.

Physician's/Prescriber's Original Signature_____ Date M M D D Y Y Y Y