MERCK VACCINE PATIENT ASSISTANCE PROGRAM APPLICATION

IMPORTANT: A dose of Merck vaccine should not be administered until after the Merck Vaccine Patient Assistance Program provides a confirmation number. This includes subsequent doses in a multi-dose series as a new application for each dose is required. Doses of vaccine administered prior to application submission and/or receipt of a confirmation number will not receive replacement product.

SECTION 1: Applicant Information *(Patient should complete all information in Section 1.)*

Patient's First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ US Resident* ☐ Yes ☐ No

Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Apt. No. ☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ State ☐☐ ZIP ☐☐☐☐☐

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

Do you have Medicare insurance? ❑ Yes ❑ No

Medicare beneficiaries only: Do you have Medicare Part D? ❑ Yes ❑ No

Do you have any other health insurance coverage of any kind *(public or private)*? ❑ Yes ❑ No

Examples: *Medicaid, veterans benefits, health maintenance organization (HMO), preferred provider organization (PPO), college health plan, federal or state insurance, or health assistance program*

Are you covered under another individual's health insurance plan? ❑ Yes ❑ No

Are you claimed as a dependent on another individual's tax return? ❑ Yes ❑ No

Current annual household income: $______________ Number in household dependent on income *(including applicant)*: ______

*You do not need to be a US citizen.

Please read the *Applicant Declarations* and *Applicant Authorization* and sign each section to indicate your agreement.

Applicant Declarations

I verify that the information provided in this application is complete and accurate and that without enrollment in the Merck Vaccine Patient Assistance Program I would not be able to afford this vaccine. I understand that my eligibility for this program and any program assistance will terminate if the program becomes aware of any fraud or if this vaccine is no longer indicated for me.

I understand that Merck & Co., Inc. reserves the right at any time and without notice to modify the criteria for eligibility for this program, or to modify or discontinue this or any program. I understand that completing this application does not ensure that I will qualify for this program. I further certify that I will not seek reimbursement or credit for this vaccine from any insurer, health maintenance organization, or government program. If I am a member of a Medicare Part D plan, I will not seek to have this vaccine or any cost associated with it counted as part of my expenditure or out-of-pocket cost for prescription drugs.

Patient's Original Signature:____**Date:**____________________

Applicant Authorization

I authorize the Merck Vaccine Patient Assistance Program and its administrators to obtain and disclose information from my prescribing physician and other information as necessary to complete the application process or verify the accuracy of any information provided in this application and in order to provide services through this program. I further authorize the program and its administrators to use and disclose my personal medical information relating to this prescription to Medicare, my plan, and their contractors for the purpose of coordination of benefits and verifying the statements made by my physician and myself in connection with my enrollment in the program. I understand that my name, address, and any other personal identifying information provided in this application will be available only to Merck, its affiliated companies, and its subcontractors, except as authorized by me or required by law. The role of Merck, its affiliated companies, and its subcontractors shall be limited to administrative functions, including data entry and verifying the accuracy and completion of eligibility and enrollment information contained in this application form. I understand that Merck is not responsible for checking or verifying any information contained in Section 2. With respect to this application I understand that only the licensed prescriber will be responsible for the information contained in Section 2. I also understand that I may receive a copy of this authorization and that, unless I change my selection sooner, my authorization will expire 15 months from the date signed below.

Patient's Original Signature:____**Date:**____________________

Patient First, Last Name: ____

SECTION 2: Licensed Prescriber Information *(Healthcare provider should complete Sections 2 and 3.)*

First, Last Name:____

Practice/Clinic Name: ____

Address: ____

City: ______________________________ State: _______ ZIP: ___________

Note: The address you provide above is where Merck will ship the replacement dose.

Type of Licensed Prescriber: ❑ Physician ❑ Nurse Practitioner ❑ Physician Assistant ❑ Certified Nurse Midwife

State License Number: #______________________________(must be active and valid)

Is this patient seeing you at a public practice, (ie, one that is wholly owned and operated by the government)?
❑ Yes ❑ No

Office Contact Person: ____

Phone Number: ______________________ Fax Number: ______________________

❑ I have a Merck Direct Account. Account Number: #________________________

❑ I don't have a Merck Direct Account.

SECTION 3: Vaccine Information

Merck Vaccine Product Name: ______________________________ **NDC Number: #** ______________

If GARDASIL® [Human Papillomavirus Quadrivalent (Types 6, 11, 16, and 18) Vaccine, Recombinant], indicate: ❑ Dose **1** ❑ Dose **2** ❑ Dose **3**

Have you administered this dose? ❑ Yes ❑ No

To be completed after application is approved by a Merck Vaccine Patient Assistance Program Representative.

Confirmation Number: #____________________

Date of Administration: ______/______/______ **Merck Vaccine Lot Number: #**______________________

IMPORTANT: The confirmation number is valid for **30 days**. If the vaccine dose is not administered to the eligible patient within 30 days following when it was granted, then the patient must submit a new application. The office must provide the date of administration and lot number to the Merck Vaccine Patient Assistance Program for all approved doses of vaccine in order for replacement product to be provided.

Merck will replace the doses of vaccine administered to approved patients via quarterly shipments to the licensed prescriber. *[Notes: Merck retains the right to select either prefilled syringes or vials for replacement doses which may or may not be the same as what was administered to approved patients. M-M-R® $_{II}$ (Measles, Mumps, and Rubella Virus Vaccine Live) and PNEUMOVAX® 23 (Pneumococcal Vaccine Polyvalent) are not available in single-dose units; therefore, these vaccines can be shipped only when the minimum threshold is reached.*

Licensed Prescriber Declarations

I verify that the information provided on this application is complete and accurate. I understand that the patient must be part of the population for which the administered vaccine is indicated and I certify that this vaccine is medically indicated for this patient. I understand that the patient must qualify financially and meet the program criteria to be eligible for assistance.

The product administered to the above patient on the date(s) above will be considered a donation to the patient from the Merck Vaccine 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 & Co., Inc., whether for administration fees or otherwise. I will not seek reimbursement for administration of vaccine from any public payer. Additionally, reimbursement for the cost of the product administered to the above patient on the date(s) above has not been sought and will not be sought from any source.

I understand that Merck & Co., Inc., 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), of all entities receiving replacement of inventory in connection with the Merck Vaccine Patient Assistance Program. 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.

My signature below confirms that the vaccine product will be provided free of charge to this individual. I verify that to the best of my knowledge the 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 to the Internal Revenue Service upon request.

Licensed Prescriber's Original Signature:____________________________________ **Date:**__________

(No stamps accepted)

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