THE MERCK PATIENT ASSISTANCE PROGRAM

PRODUCT REPLACEMENT FORM

KEYTRUDA® (pembrolizumab) Injection 100 mg

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

Patient name:_____

THIS FORM SHOULD BE COMPLETED BY HEALTH CARE PROVIDERS, NOT PATIENTS.

INSTRUCTIONS FOR HEALTH CARE PROVIDERS APPLYING FOR PRODUCT REPLACEMENT THROUGH THE MERCK PATIENT ASSISTANCE PROGRAM

Health care providers: Please follow these instructions to ensure that all necessary information is provided. Missing information will delay the process.

Product replacement may be available for patients who do not have insurance or whose insurance does not cover the product, if the patient meets certain financial, medical, and insurance criteria.

Please ensure the following are submitted with this completed form:

- A completed Merck Access Program Enrollment Form, including all sections necessary for the Merck Patient Assistance Program
- For patients who have insurance, but whose insurer does not cover the product, a copy of the initial claim denial. An appeal denial may be necessary. A program representative can help explain this requirement

IMPORTANT : The Merck Access Program Enrollment Form must accompany this Merck Patient Assistance Program Product Replacement Form. Please ensure that both the patient and physician have signed the Enrollment Form, including all sections necessary for the Merck Patient Assistance Program.

A program representative will contact the physician's office once this Merck Patient Assistance Program Product Replacement Form has been received to obtain additional information.

Patient name:_____

PRODUCT REPLACEMENT (to be completed by health care providers)

Product name: _____ Date(s) of administration: _____

PATIENT INFORMATION

Patient name: _____ Date of birth: _____

Place of administration/Facility name: _____ Office contact: _____

Address: _____

(Please provide a street address only, no PO boxes. Replacement product will be shipped to this facility address.)

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Physician name: _____

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

HEALTH CARE PROVIDER DECLARATION

Health care provider name: _____

I verify that the information provided on this application is complete and accurate. I understand that the patient must meet certain medical and financial criteria to be eligible for assistance. The product administered to the above patient will be considered a donation to the patient from the Merck 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 Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc., or the Merck Patient Assistance Program, Inc. ("Foundation"), whether for administration fees or otherwise. Reimbursement for the cost of the product administered to the above patient on the date(s) indicated has not been sought and will not be sought from any source. Acceptance of this replacement product in no way obligates my facility to use the selected product for other patients. Additionally, I understand that the Foundation reserves the right to conduct periodic audits of the records, excluding patient-identifiable data (unless the auditor enters into an appropriate agreement with the facility to protect an individual's medical privacy), of all entities receiving product replacement. 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. I understand that the Foundation reserves the right to modify or revoke this program at any time without notice.

My signature confirms that this product was provided free of charge to this patient. I verify that to the best of my knowledge this 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 upon request, as applicable.

Health care provider signature: _____ Date: _____

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