THE MERCK ACCESS PROGRAM

ENROLLMENT FORM

WELIREG™ (belzutifan) 40 mg tablets

Please read the accompanying Medication Guide for WELIREG, including an important warning about harm to an unborn baby, and discuss it with your doctor. The physician Prescribing Information also is available.

Phone: 855-257-3932 Fax: 855-755-0518 • The Merck Access Program, PO Box 2349, Columbus, OH 43216

Prescriptions for WELIREG can be filled through EITHER the specialty pharmacy network or certain physician practices with dispensing capabilities and certain hospital pharmacies. Please select the appropriate option below for how your patients can obtain WELIREG.

Specialty Pharmacy Network

Option 1: If a specialty pharmacy has referred your patient to The Merck Access Program (MAP) to determine eligibility for PAP, please select which pharmacy made the referral:

☐ Biologics Pharmacy ☐ Onco360 Oncology Pharmacy

Please complete sections 2–8, as applicable, to have your patient referred to the Merck PAP for eligibility determination.

Certain Physician Practices With Dispensing Capabilities & Certain Hospital Pharmacies

Option 2: If your facility is dispensing WELIREG, please check all boxes below that apply.

☐ Patient Benefit Investigation and/or information about the Prior Authorization or Appeals Process

☐ Referral to the Merck PAP for eligibility determination (provided through the Merck Patient Assistance Program, Inc.)

Please complete sections 1–8, as applicable, to enroll your patient in The Merck Access Program (MAP).

Section 1: Insurance Information

INSURANCE INFORMATION (REQUIRED)

Please complete all that apply and include a front and back copy of insurance card for each type of insurance

Is Prior Authorization on file with the Payer? ☐ Yes ☐ No AUTH #:_____

PA Approval Dates: _____

☐ Patient has no insurance

☐ Patient has insurance through Medicare: ☐ Yes ☐ No

(If yes:) ☐ Part A ☐ Part B ☐ Part D ☐ Medicare Advantage

	PRIMARY INSURANCE	SECONDARY INSURANCE
PLAN NAME AND STATE		
NAME OF POLICYHOLDER		
POLICYHOLDER DATE OF BIRTH		
POLICYHOLDER RELATION TO PATIENT		
PHONE NUMBER FOR CUSTOMER SERVICE		
GROUP NO.		
POLICY ID NO.		

Section 2: Patient Information

PATIENT INFORMATION

Patient is a US resident: ☐ Yes ☐ No

Patient name: _____ Date of birth (mm/dd/yy): _____ Sex: ☐ M ☐ F

Address: _____ City/state/zip: _____
(Street address only, no PO boxes)

Phone (home): _____ (work/other): _____

Email: _____

PATIENT AUTHORIZATION

I understand that, before I may have communications with The Merck Access Program, sponsored by Merck Sharp & Dohme LLC ("Merck"), a subsidiary of Merck & Co., Inc., or receive assistance from the Merck Patient Assistance Program ("Merck 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 included 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 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 (i) use my PHI to provide the services described in this enrollment form, including to communicate with me by US postal mail, telephone, text, or email and to prepare summaries that do not include my PHI for statistical purposes; and (ii) share my PHI with one another and with my physicians and pharmacists as well as with 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, representatives, and third-party services partners to disclose my PHI to authorized representatives of Merck as necessary to ensure compliance with the rules of the Programs. I also authorize Merck's authorized representatives to use my PHI to communicate with the administrators of the Programs, their contractors, representatives or third-party services partners, my physicians, pharmacies, and me for compliance purposes.

If I have a designated Personal Representative, to use my PHI to contact the person I have designated as my Legal 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 Legal Representative for the purposes described above.

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 healthcare insurance benefits, but that I will not be able to receive any assistance from the Programs for which I may be eligible.

PATIENT AUTHORIZATION

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 2349, Columbus, OH 43216. I understand that canceling my authorization will mean that my physicians, pharmacies, and health plans, as well as Fortrea and the Programs, their respective administrators, and their contractors and representatives, may no longer rely on the authorization to use or disclose my PHI, 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 of signature (or the maximum period allowed by applicable state law, if less than 15 months). 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.

By signing, I certify that I have read and agree to the above Patient Authorization based on the support I have requested.

PATIENT SIGNATURE

Signature of patient or legal representative*: _____ **Date:** _____

*A legal representative is a person who has legal authority under applicable state law to bind you (the patient) by signing each authorization or declaration in the enrollment form.

Name of signing party (please print): _____

DECLARATION OF LEGAL REPRESENTATIVE (If Applicable)

☐ 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.

Phone number of legal representative: _____

Relationship of legal representative to patient: _____

Section 4: The Merck Patient Assistance Program (PAP) Terms And Conditions

To be eligible for enrollment in the Merck PAP for the Program Product, Patient must request referral to the Merck PAP (see checkbox on page 1) and meet the following Merck PAP eligibility requirements, as determined by the Merck PAP:

- Patient is a US resident and has a prescription for the Program Product from a doctor or prescriber licensed in the US.
- Patient does not have insurance or other coverage for the Program Product.
- Patient meets certain financial eligibility criteria.

HOUSEHOLD INCOME INFORMATION MUST BE PROVIDED FOR ENROLLMENT IN MERCK PAP

Current annual gross household income* (parent/guardian if patient is under age 18): $ _____

Number of household members (including patient): _____

*Total gross income before taxes, received within a 12-month period by all members of a household age 15 and older. (Please include before-tax wages, pension, interest/dividends, Social Security benefits, and any other sources of income.)

If Patient is accepted into the Merck PAP, the following Terms and Conditions apply:

- Assistance will terminate if the Merck PAP becomes aware of any fraud or if the Program Product is no longer prescribed for Patient.
- Completing this Form does not guarantee that Patient will qualify for patient assistance.
- Patient will not seek reimbursement or credit for this prescription from any insurer, health plan, or government program. If Patient is a member of a Medicare Part D plan, patient will not seek to have the prescription or any cost associated with it counted as part of Patient's out-of-pocket cost for prescription drugs.
- Merck PAP reserves the right to modify or discontinue this program, or terminate assistance at any time and without notice.
- Patient authorizes Merck PAP and its affiliates to forward the prescription to a dispensing pharmacy, certain physician practices, or certain hospital pharmacies on Patient's 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 Patient.
- Patient will notify the Merck PAP immediately if anything changes with Patient's prescription, income, or insurance coverage.
- The Merck PAP reserves the right to request documentation to verify the information provided in this enrollment form for purposes of determining Patient eligibility for assistance, and to conduct periodic audits of Patient's enrollment, including the physician who will be supervising treatment, to verify the information provided herein.
- Assistance received through the Merck Patient Assistance Program is not insurance.

Section 5: Merck PAP Financial Hardship Exception

☐ **Patient requests consideration for Merck PAP Financial Hardship Exception**

If Patient does not meet the prescription drug coverage criteria, Patient may still request assistance if experiencing a financial hardship (i.e., cannot afford the deductible, co-pay, co-insurance, or other cost-sharing requirement of their insurance plan). Patient eligibility request and enrollment under the financial hardship exception is subject to the following terms and conditions:

- The decision of whether Patient is approved for a financial hardship exception resides exclusively with the Merck PAP.
- If Patient has Medicare coverage, eligibility will automatically expire on December 31 of the current calendar year and Patient must submit a new enrollment form before December 31 for eligibility determination for the following year. If Patient fails to re-enroll before December 31, Patient will no longer receive their medication from the Merck PAP.
- If Patient has private prescription drug coverage, eligibility will automatically expire one (1) year from date of enrollment and Patient must re-enroll for eligibility determination for the following year.

Section 6: Patient Acknowledgment And Signature

By signing, I certify that I have read and agree to the above terms and conditions of the Merck PAP and the Merck PAP Financial Hardship Exception, as applicable, based on the support I have requested. By signing, I also certify that all information that I have provided in this application is complete and accurate.

PATIENT SIGNATURE

Signature of patient or legal representative: _____ **Date:** _____

Name of signing party (please print): _____

Relationship to patient (if other than patient signing): _____

Section 7: Healthcare Provider Information

HEALTHCARE PROVIDER INFORMATION (to be completed by healthcare provider)

Healthcare provider name: _____

Healthcare provider tax ID #: _____ Healthcare provider NPI #: _____

Practice/Facility name: _____ Practice tax ID #: _____

Practice NPI #: _____

Address: _____ City/state/zip: _____
(Street address only, no PO boxes)

Phone: _____ Fax: _____

Office contact person: _____ Office contact number: _____

Email: _____

Product use is consistent with labeled indications for WELIREG™ (belzutifan): ☐ Yes ☐ No

Section 8: Healthcare Provider Attestation

HEALTHCARE PROVIDER ATTESTATION

By signing below, I represent and warrant the following:

- This Enrollment Form has been prepared exclusively by the healthcare provider or healthcare provider office identified in this Enrollment Form.
- By signing below, I represent and warrant that I am authorized pursuant to the laws of my state of license to prescribe WELIREG.

HEALTHCARE PROVIDER ATTESTATION

- I or others in my healthcare provider practice group ("my Practice") have obtained written authorization from the patient named in this Enrollment Form that complies with the requirements of the HIPAA Privacy Rule, 45 C.F.R. §164.508, and authorizes me and my Practice, as well as the patient's health insurance plan(s), 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 Enrollment Form to The Merck Access Program (the "Access Program") and the Merck Patient Assistance Program ("Merck PAP") (collectively, "the Programs") and authorizes the Programs, including their contractors or other affiliates, to use and disclose the PHI for purposes of benefits investigation and reimbursement support.
- I certify that I, or a healthcare provider in my Practice, have determined that the prescribed product is medically appropriate for the patient identified above and that I, or a healthcare provider in my Practice, will be supervising the patient's treatment.
- If the patient receives product through the Merck PAP, neither I nor my Practice will seek reimbursement for such product administered to the patient from any source.
- Neither I nor my Practice will receive any reimbursement from Merck, whether for administrative 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 only for use in an aggregated, de-identified format.
- I and my Practice grant the Programs the right to conduct periodic audits of my Practice's records to verify the information provided herein.
- I consent to receive communications related to the Programs by telephone, email, and/or fax.
- I understand that the Programs reserve the right to modify or discontinue this program at this facility/practice, or terminate assistance at any time and without notice.
- The information provided is complete and accurate to the best of my knowledge.

By signing, I certify that I have read and agree to the above Healthcare Provider Certification and Attestation (if applicable based on the support my patient requested). By signing, I also certify that all information that I have provided in this enrollment form is complete and accurate.

HEALTHCARE PROVIDER SIGNATURE

Healthcare provider signature: _____ Date: _____

Healthcare provider name (please print): _____

Healthcare provider designation (MD, DO, NP, PA, other): _____

To report a suspected adverse event involving a specific Merck product, please contact the Merck National Service Center at 800-444-2080.

MERCK