The Merck Access Program
2024 ENROLLMENT FORM

ZINPLAVA™ (bezlotoxumab) Injection 25 mg/mL

P: 877-709-4455, F: 800-977-1957 • The Merck Access Program, PO Box 2349, Columbus, OH 43216

TO GET STARTED, COMPLETE THE ENROLLMENT FORM AND SUBMIT ONLINE, OR PRINT AND FAX THE COMPLETED DOWNLOADABLE FORM TO 800-977-1957. IF REQUESTING A REFERRAL TO THE MERCK PATIENT ASSISTANCE PROGRAM, PLEASE INCLUDE A PRESCRIPTION FOR ZINPLAVA.

PLEASE CHECK ALL BOXES THAT APPLY AND COMPLETE THE APPROPRIATE SECTION(S) OF THE FORM

- ☐ **Patient Benefit Investigation and/or information about the Prior Authorization or Appeals Process**
- ☐ **Merck Co-pay Assistance Program**
- ☐ **Referral to the Merck Patient Assistance Program for eligibility determination (provided through the Merck Patient Assistance Program, Inc.*)**

*Merck PAP, Inc. is a 501c3 Foundation and is separate and distinct from The Merck Access Program.
If you and your patient are requesting benefits investigation and/or information about prior authorization or appeals ONLY, then a patient signature is not required.
Please note: If patient does not complete and sign, The Merck Access Program will not contact the patient.

PATIENT INFORMATION SECTION

1 PATIENT INFORMATION (REQUIRED)

Patient is a US resident: ☐ Yes ☐ No

Patient name: _____ Date of birth: _____ Sex: ☐ M ☐ F

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

Phone (home): _____ (mobile): _____

E-mail: _____

Preferred Communication: ☐ Phone ☐ E-mail ☐ Mail

2 INSURANCE INFORMATION (REQUIRED)

*PLEASE COMPLETE ALL THAT APPLY AND **INCLUDE A FRONT AND BACK COPY OF INSURANCE CARD** FOR EACH TYPE OF INSURANCE*

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

☐ **Patient Has No Insurance**

Patient Has Insurance Through Medicare: ☐ **Yes** ☐ **No**
(If Yes) ☐ **Part A** ☐ **Part B** ☐ **Part D** ☐ **Medicare Advantage**

Primary Insurer (including Medicaid, Medicare, veterans' benefits, private insurers)

Plan name and state*: _____

Phone (customer service): _____ Name of policyholder: _____

Policyholder date of birth (mm/dd/yyyy): _____ Policyholder relationship to patient: _____

Policy ID #*: _____ **Group #:** _____

Secondary/Supplemental Insurer (including Medicaid, Medicare, veterans' benefits, private insurers)

Plan name and state: _____

Phone (customer service): _____ Name of policyholder: _____

Policyholder date of birth (mm/dd/yyyy): _____ Policyholder relationship to patient: _____

Policy ID #: _____ Group #: _____

Patient Name: _____

PATIENT INFORMATION SECTION

3 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 related to my treatment with ZINPLAVA, information on my request form and any prescription for ZINPLAVA (my "PHI").

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 respective contractors or representatives to (i) use my PHI to provide the services described in this enrollment form, including to communicate with me by U.S. postal mail, telephone, text, or e-mail 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 designated a Personal Representative, I authorize the Programs, their administrators, and their third-party services partners to use my PHI to contact the person I have designated as my Personal 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 Personal Representative for the purposes described in this paragraph.

I understand that if I do not sign this Authorization, that will not affect my receipt of treatment (including with ZINPLAVA) or of health insurance benefits, but that I will not be able to obtain certain assistance provided by the Programs on behalf of Merck. I understand that I may cancel this Authorization at any time by telephoning The Merck Access Program at (877) 709-4455 or by mailing a written request for such cancellation to the administrators of the Programs, PO Box 2349, Columbus, OH 43216. I understand that canceling my Authorization will not affect uses and disclosures of PHI already made in reliance on the Authorization before my cancellation is received by the administrators of the Programs.

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). Merck has retained the Programs to provide support to customers, including reimbursement support. Information and questions related to the information provided in regard to this request should be referred directly to the administrators of the Programs. Merck personnel are not aware of patient-specific reimbursement information and are not permitted to discuss such information with customers.

I understand that I may request 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: _____

Name of signing party (please print): _____

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

Patient Name: _____

PATIENT INFORMATION SECTION

4 THE MERCK CO-PAY ASSISTANCE PROGRAM TERMS AND CONDITIONS

The Merck Co-pay Assistance Program for ZINPLAVA™ (bezlotoxumab) Injection 25 mg/mL ("Program Product")

To receive benefits under the Co-pay Assistance Program, the patient must enroll in the Co-pay Assistance Program and be accepted as eligible. Patient may contact The Merck Access Program for current Program Product(s) subject to these Terms and Conditions.

- Patient must be prescribed the Program Product for an FDA-approved indication.
- Patient must be 18 years of age or older and must have private health insurance that provides coverage for the cost of the Program Product under a medical benefit plan.
- **The Co-pay Assistance Program is not valid for patients covered under Medicaid (including Medicaid patients enrolled in a qualified health plan purchased through a health insurance exchange [marketplace] established by a state government or the federal government), Medicare, a Medicare Part D or Medicare Advantage plan (regardless of whether a specific prescription is covered), TRICARE, CHAMPUS, Puerto Rico Government Health Insurance Plan ("Healthcare Reform"), or any other state or federal medical or pharmaceutical benefit program or pharmaceutical assistance program (collectively, "Government Programs"). The Co-pay Assistance Program is not valid for uninsured patients.**
- Patient must be a resident of the United States or the Commonwealth of Puerto Rico. Product must originate and be administered to patient in the United States or the Commonwealth of Puerto Rico.
- **Subject to changes in state law, the Co-pay Assistance Program may become invalid for residents of Massachusetts prior to its expiration date.**
- All information applicable to the Co-pay Assistance Program requested on The Merck Access Program Enrollment Form must be provided, and all certifications must be signed. Forms that are modified or do not contain all the necessary information will not be eligible for benefits under the Co-pay Assistance Program.
- **Patient must pay the first $100 of co-pay per administration of Program Product.** The benefit available under the Co-pay Assistance Program is limited to the amount the patient's private health insurance company indicates on the Explanation of Benefits (EOB) that the patient is obligated to pay for the Program Product, less $100, up to a maximum benefit of $3,700 for one (1) vial of Program Product. If two (2) vials of Program Product are required to be administered in one infusion, the patient is obligated to pay for the Program Product, less $100, up to a maximum benefit of $7,500. Co-pay assistance is available on a subsequent administration of Program Product, provided patient remains enrolled in the Program and remains eligible, provided however, that co-pay assistance is not available on any administration of Program Product that occurs less than 100 days after any previous administration of Program Product for which co-pay assistance was sought. Subsequent administration is subject to all Terms and Conditions.
- Patient must have an out-of-pocket cost for the Program Product and be administered the Program Product prior to the expiration date of the Co-pay Assistance Program. The benefit available under the Co-pay Assistance Program is valid for the patient's out-of-pocket cost for the Program Product only. It is not valid for any other out-of-pocket costs (for example, office visits charges or medication administration charges) even if such costs are associated with the administration of the Program Product. Claim for Program Product must be submitted by healthcare provider to patient's private health insurance separately from other services and products.
- An EOB from patient's private health insurance must be submitted, along with all other required documentation in support of the Co-Pay Assistance Program claim, within **180 days** of the date of the EOB for patient to receive co-pay assistance benefit; provided, however, that no EOB or required documentation may be submitted more than **180 days** after the expiration date of Co-pay Assistance Program. The EOB must reflect the patient's out-of-pocket cost for the Program Product and submission of the claim by the patient's healthcare provider for the cost of the Program Product.
- The Co-pay Assistance Program may apply to patient out-of-pocket costs incurred for a Program Product that was administered **up to 90 days** prior to the date patient is enrolled in the Co-pay Assistance Program, subject to the applicable Terms and Conditions based on Program Product administration date.
- Patient and healthcare provider agree not to seek reimbursement for all or any part of the benefit received by the patient through the Co-pay Assistance Program. Patient and healthcare provider are responsible for reporting receipt of Co-pay Assistance Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Co-pay Assistance Program, as may be required.
- No other purchase is necessary.
- **The Co-pay Assistance Program is not insurance.**
- The Merck Access Program Enrollment Form may not be sold, purchased, traded, or counterfeited. Void if reproduced.
- The Co-pay Assistance Program is void where prohibited by law, taxed, or restricted. The Co-pay Assistance Program is not transferable. No substitutions are permitted.
- The Co-pay Assistance Program benefit cannot be combined with any other Co-pay Assistance Program, free trial, discount, prescription savings card, or other offer. Benefits are not available through this Co-pay Assistance Program for product purchased by patient at a pharmacy, even if later administered in a healthcare provider office or outpatient institution.
- Merck reserves the right to rescind, revoke, or amend the Co-pay Assistance Program at any time without notice.
- Data related to patient's receipt of Co-pay Assistance Program benefits may be collected, analyzed, and shared with Merck, for market research and other purposes related to assessing Co-pay Assistance Programs. Data shared with Merck will be aggregated and de-identified, meaning it will be combined with data related to other Co-pay Assistance Program redemptions and will not identify patient.
- These Terms and Conditions are valid for Program Product administered between January 1, 2024, and December 31, 2024.
- **Expiration Date: 12/31/2024.**

Patient Name: _____

PATIENT INFORMATION SECTION

5 PATIENT CERTIFICATION: THE MERCK CO-PAY ASSISTANCE PROGRAM

I certify that I have read and understand the Terms and Conditions of the Merck Co-pay Assistance Program for ZINPLAVA™ (bezlotoxumab) Injection 25 mg/mL ("Program Product"). I certify that I meet the eligibility requirements listed in the Terms and Conditions and that the information I am providing on The Merck Access Program Enrollment Form is true and correct.

I certify that I have private insurance and that no part of the costs associated with the Program Product for which I am seeking a benefit under the Co-pay Assistance Program was or will be covered or reimbursed by a Government Program, as that term is defined in the Terms and Conditions of the Co-pay Assistance Program.

I understand that if I begin to have coverage under any Government Program or if my state prohibits the redemption of manufacturer Co-pay Assistance (coupons) at any time, I will no longer be eligible to receive benefits under the Co-pay Assistance Program. If I am enrolled in a qualified health plan purchased through a health insurance exchange established by a state government or the federal government (QHP), I understand that if the federal government or my state government prohibits the redemption of manufacturer Co-pay Assistance (coupons) by enrollees in QHPs at any time, I will no longer be eligible to receive benefits under the Co-pay Assistance Program.

I certify that my insurance company has not prohibited the redemption of manufacturer Co-pay Assistance (coupons) for the Program Product, and I understand that if at any time my insurance company prohibits the redemption of manufacturer Co-pay Assistance (coupons) for the Program Product, I will no longer be eligible to receive benefits under the Co-pay Assistance Program.

I understand that I am responsible for reporting receipt of Co-pay Assistance Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Co-pay Assistance Program, as may be required.

I agree not to seek reimbursement for all or any part of the benefit I receive through the Co-pay Assistance Program. I understand that my healthcare provider/healthcare provider's office will submit a claim to my private insurance company for the Program Product administered to me.

I understand that any benefit I am eligible for under the Co-pay Assistance Program may be paid directly to my healthcare provider/healthcare provider's office, on my behalf, or, if I have already paid my share of the cost of the Program Product, may be paid directly to me.

I may choose to authorize my healthcare provider to submit the Explanation of Benefits received from my private insurance company to the Co-pay Assistance Program and to receive, on my behalf, any benefit for which I am eligible under the Program. I understand that my healthcare provider/healthcare provider's office will apply any amounts received from the Co-pay Assistance Program toward the satisfaction of my obligation for the cost of the Program Product only. I understand that I am responsible to pay my healthcare provider/healthcare provider's office the amount I owe per administration of Program Product consistent with the applicable Terms and Conditions of the Co-pay Assistance Program, and any balance owed to my healthcare provider/healthcare provider's office not covered by the Co-pay Assistance Program. If I have already paid my share of the cost of the Program Product, I will seek the amount of the benefit paid on my behalf from the Co-pay Assistance Program back from my healthcare provider/healthcare provider's office. Alternatively, if I have already paid my healthcare provider for my share of the cost of the Program Product, I may submit to the Co-pay Assistance Program the Explanation of Benefits I (or my healthcare provider) received from my private insurance company indicating the amount I am obligated to pay for the cost of the Program Product, along with all required documentation, including an invoice from my healthcare provider's office and a receipt reflecting the amount I paid my healthcare provider for the cost of the Program Product. I understand that the Co-pay Assistance Program will deny any claim for Co-pay Assistance for which inadequate, illegible, or unclear documentation has been received. I understand that any benefit for which I am eligible under the Co-pay Assistance Program will be paid only one time, either to my healthcare provider on my behalf or directly to me.

I understand that I am free to switch healthcare providers at any time without affecting my eligibility to receive benefits under the Co-pay Assistance Program, provided, however, that my new healthcare provider must complete the information required on the form, including the Healthcare Provider Certification, before any Co-pay Assistance Program benefit for which I am eligible may be paid, if applicable, to such healthcare provider on my behalf.

I understand that co-pay assistance for any administration of Program Product to me between January 1, 2024 and December 31, 2024 is subject to the 2024 Co-pay Assistance Program Terms and Conditions.

I will inform the Co-pay Assistance Program immediately in the event my health insurance changes (for example, at the beginning of a new calendar or benefit year).

6 THE MERCK PATIENT ASSISTANCE PROGRAM (MERCK PAP) TERMS AND CONDITIONS

To be eligible for enrollment in the Merck PAP for ZINPLAVA (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 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 PAP is not insurance.

Patient Name: _____

PATIENT INFORMATION SECTION

7 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.

8 PATIENT ACKNOWLEDGMENT AND SIGNATURE

By signing, I certify that I have read and agree to the above Terms and Conditions and Patient Certification of the Merck Co-Pay Assistance Program and the 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): _____

HEALTHCARE PROVIDER INFORMATION SECTION

9 DIAGNOSIS / TREATMENT INFORMATION (REQUIRED)

Please indicate the diagnosis code(s): ☐ **A04.71** ☐ **A04.72** ☐ **Other** _____

Anticipated administration date: _____

Patient history: ☐ Initial episode ☐ Prior episode in the past six months

10 HEALTHCARE PROVIDER INFORMATION (REQUIRED)

Healthcare provider name: _____

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

Healthcare provider tax ID #: _____

Healthcare provider NPI #: _____

Healthcare provider State license #: _____

Healthcare provider State license # expiration date: _____

Address: _____
(Street address only, no PO boxes)

City/state/zip: _____

Phone: _____

Fax: _____

Office contact person: _____

Office contact number: _____

Office contact e-mail: _____

Preferred Communication: ☐ Phone ☐ E-mail ☐ Mail

Practice/Facility name: _____

Practice tax ID #: _____

Practice NPI #: _____

Practice/Facility address: _____
(Street address only, no PO boxes)

City/state/zip: _____

Site of Care:

☐ Hospital outpatient department
☐ Infusion clinic
☐ Healthcare provider office
☐ Other: _____

Patient Name: _____

HEALTHCARE PROVIDER INFORMATION SECTION

11 HEALTHCARE PROVIDER CERTIFICATION: THE MERCK CO-PAY ASSISTANCE PROGRAM

I, a licensed healthcare professional, certify that ZINPLAVA™ (bezlotoxumab) Injection 25 mg/mL ("Program Product") has been prescribed to the patient indicated on The Merck Access Program Enrollment Form in the exercise of the prescriber's independent medical judgment for an FDA-approved indication.

I have read and agree to the Terms and Conditions of the Merck Co-pay Assistance Program. I certify that, to the best of my knowledge, the patient meets the criteria set forth in the Terms and Conditions, and that the information I am providing is true and correct.

I certify that I/my office will not take into account the fact that the patient may receive a benefit from the Co-pay Assistance Program when determining the amount of any charge(s) to the patient. I certify that I/my office will not charge the patient any fee to complete The Merck Access Program Enrollment Form and I/my office will not advertise or otherwise use the Co-pay Assistance Program as means of promoting my services or the Program Product.

I certify that the claim I submit/my office submits to the patient's private health insurer for payment of the Program Product will have the Program Product listed separately from any claim for medication administration or any other items or services provided to the patient.

I understand that I am/my office is responsible for reporting receipt of Co-pay Assistance Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Co-pay Assistance Program, as may be required.

I certify that I/my office will not seek reimbursement for all or any part of the benefit received by the patient through the Co-pay Assistance Program.

I understand that the patient's benefit received under the Co-pay Assistance Program may be paid directly to me/my office by the Co-pay Assistance Program on behalf of my patient, or, if my patient has already paid the patient's share of the cost of the Program Product, may be paid directly to the patient. I/my office will apply any amounts received from the Co-pay Assistance Program to the satisfaction of the patient's obligation for the cost of the Program Product only. If the patient's Co-pay Assistance Program benefit is paid to me/my office on behalf of my patient and I/my office already received payment from the patient for the patient's share of the cost of the Program Product, I/my office will refund the amounts received (minus the patient's obligation per administration in accordance with the Co-pay Assistance Program Terms and Conditions) back to the patient.

I understand and agree that the certifications I am providing in this Healthcare Provider Certification apply to the patient indicated on The Merck Access Program Enrollment Form and to any other patient enrolled in the Co-pay Assistance Program who I treat with the Program Product and any claim I submit/my office submits for Co-pay Assistance Program benefits on the patient's behalf. I understand that I may be asked to sign a new Healthcare Provider Certification if the Terms and Conditions of the Co-pay Assistance Program for the Program Product change.

12 HEALTHCARE PROVIDER ATTESTATION (REQUIRED)

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 ZINPLAVA.
- 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 the 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 represent and warrant that if my Practice uses a Third-Party Administrator (TPA), the TPA is authorized to act on my behalf to submit enrollment forms to Merck PAP and that the TPA has been trained on Merck PAP rules and requirements before providing services related to Merck PAP.
- I understand that a TPA may not sign on behalf of the patient.
- 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.
- I certify that the Program Product is being used in an outpatient setting only.
- 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.
- I understand that any donated product from Merck PAP must be returned if the specific eligible patient is unable to receive treatment for any reason and may not be used for any other patient other than the Merck PAP patient for whom it was intended.
- Neither I nor my Practice will receive any reimbursement from Merck, whether for administration 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 Programs the right to conduct periodic audits of my Practice's records to verify the information provided herein.
- 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.
- I consent to receive communications related to the Programs by telephone, e-mail, and/or fax.
- The information provided is complete and accurate to the best of my knowledge.

Does the Facility use a Third-Party Administrator (TPA) to administer and manage its patient assistance programs? ☐ Yes ☐ No

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