The Merck Access Program

ENROLLMENT FORM

PREVYMIS™ (letermovir)
240 mg, 480 mg tablets

Phone: 855-404-5278 Fax: 866-866-4127 • The Merck Access Program, PO Box 29067, Phoenix, AZ 85038

TO GET STARTED, COMPLETE THE ENROLLMENT FORM AND SUBMIT ONLINE, OR PRINT AND FAX THE COMPLETED DOWNLOADABLE FORM TO 866-866-4127. IF REQUESTING A REFERRAL TO THE MERCK PATIENT ASSISTANCE PROGRAM, PLEASE INCLUDE A PRESCRIPTION FOR PREVYMIS.

PATIENT INFORMATION SECTION

1 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

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

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.

2 PATIENT INFORMATION (REQUIRED)

Patient is a US resident: ☐ Yes ☐ No

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

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

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

E-mail: _____

3 INSURANCE INFORMATION (REQUIRED)

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

☐ 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, and private insurers)

Is this a Medicare Part D plan? ☐ Yes ☐ No

Plan name and state: _____

Phone number for customer service: _____

Subscriber name: _____ Name of policyholder: _____

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

Policy ID #: _____ Group #: _____

Secondary/supplemental insurer

Is this a Medicare Part D plan? ☐ Yes ☐ No

Plan name and state: _____

Phone number for customer service: _____

Subscriber name: _____ Name of policyholder: _____

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

Policy ID #: _____ Group #: _____

REQUIRED FOR THE MERCK PATIENT ASSISTANCE PROGRAM

Current annual gross household income* (parent/guardian if patient is under 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)

4 PATIENT AUTHORIZATION (to be completed by patient)

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 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.

PATIENT INFORMATION SECTION

4 PATIENT AUTHORIZATION (to be completed by patient) (*continued*)

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.

I understand that I may cancel this authorization at any time by telephoning The Merck Access Program at (855) 404-5278 or by mailing a written request for cancellation to The Merck Access Program, PO Box 29067, Phoenix, AZ 85038. I understand that canceling my authorization will mean that my physicians, pharmacies, and health plans, as well as the Programs, their administrators, and their contractors and representative, 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:_____

Name of signing party (please print):_____

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

Patient Name:_____

PATIENT INFORMATION SECTION

5 THE MERCK PATIENT ASSISTANCE PROGRAM (PROVIDED THROUGH THE MERCK PATIENT ASSISTANCE PROGRAM, INC.) (to be completed by patient)

I certify that all of the information provided in this application, including information about household income, is complete and accurate.

I understand that Merck PAP assistance will terminate if the Merck PAP 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 patient assistance. 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 the 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 the 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 the prescription forwarded as part of the enrollment process, including, without limitation, allergies, medical conditions, or other medications being taken by me.

I understand that I will notify the Merck PAP immediately if anything changes with my prescription, income, or my insurance coverage.

I understand that Merck PAP reserves the right to request documentation to verify the information provided in this application for purposes of determining my eligibility for assistance, and to conduct periodic audits of my enrollment, including the physician who will be supervising my treatment, to verify the information provided herein.

I understand that assistance received through the Merck Patient Assistance Program is not insurance.

6 PATIENT ACKNOWLEDGMENT AND SIGNATURE

If another person will be legally signing on behalf of the patient or if the patient would like to designate a person to act on his or her behalf to verify information and coordinate provisions of the programs described in this enrollment form, PLEASE INCLUDE A COMPLETED REPRESENTATIVE'S FORM WITH THIS ENROLLMENT FORM.

By signing, I certify that I have read and agree to the above terms and conditions of the Merck Patient Assistance Program, 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):_____

If you have questions about completing this form or need additional information, please call **855-404-5278.**

Patient Name:_____

HEALTHCARE PROVIDER INFORMATION SECTION

7 HEALTHCARE PROVIDER INFORMATION (REQUIRED) Must be completed by healthcare provider

Healthcare provider name: _____

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

Healthcare provider State license #:_____

Healthcare provider State license # expiration date: _____

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:_____

E-mail:_____

Patient Name: _____

HEALTHCARE PROVIDER INFORMATION SECTION

8 HEALTHCARE PROVIDER ATTESTATION (to be completed by licensed healthcare provider)

By signing this Attestation, you are requesting The Merck Access Program assist your patient with initiating a Benefits Investigation and/or obtaining information about the Prior Authorization or Appeals Process.

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 PREVYMIS.
- 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 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 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 Program by telephone, e-mail, 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 Attestation.

HEALTHCARE PROVIDER SIGNATURE

Healthcare provider signature: _____ Date: _____

Healthcare provider name (please print): _____

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

Is healthcare provider licensed in Vermont? ☐ Yes ☐ No If yes, provide Vermont license #: _____

To report an adverse event to a specific Merck product, including death due to any cause, please contact the Merck National Service Center at 800-444-2080.

MERCK