The Merck Access Program

REPRESENTATIVE'S 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 THIS FORM AND FAX IT TO 866-866-4127 WITH YOUR ENROLLMENT FORM.

Patient name:_____

Your legal and/or personal representative should complete this form. 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. A personal representative is a person who can act on your behalf to verify the information that is provided in the enrollment form and/or coordinate the provision of benefits available to you under the selected programs for which you are eligible.

DECLARATION OF LEGAL REPRESENTATIVE (to be completed by legal representative)

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.

Name of legal representative: _____

Relationship of legal representative to patient: _____

Legal representative's original signature: _____ Date: _____

DESIGNATION OF PERSONAL REPRESENTATIVE (to be completed by patient or legal representative)

You or your legal representative may designate a personal representative who can act on your behalf to verify the information that you provide in this form and/or coordinate the provision of benefits available to you under the selected programs for which you are eligible.

❑ Same as above

Name of personal representative: _____

Phone: _____ E-mail address: _____

Mailing address: _____

Relationship of personal representative to patient: _____

CONSENT TO ACT AS PATIENT'S PERSONAL REPRESENTATIVE (to be completed by personal representative)

I understand that I have been designated as the patient's personal representative for the purpose of communicating with The Merck Access Program, sponsored by Merck Sharp & Dohme LLC ("Merck"), a subsidiary of Merck & Co., Inc., or the Merck Patient Assistance Program ("PAP"), sponsored by the Merck Patient Assistance Program, Inc. (individually, "a Program"; collectively, "the Programs"), and the administrators of the Programs, including their contractors or other representatives, to verify the information provided by the patient in this form and/or to coordinate the provision of benefits available to the patient under the Programs. I authorize the administrators of the Programs to contact me at the mailing address, telephone number, and/or email address, listed above for that purpose.

Name of personal representative (please print): _____

Signature: _____ Date: _____

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