The Merck Access Program

ENROLLMENT FORM

PREVYMIS® (letermovir)
240 mg, 480 mg tablets
Oral pellets 20 mg, 120 mg per packet

Phone: 855-404-5278 Fax: 866-866-4127 • The Merck Access Program, PO Box 2349, Columbus, OH 43216

TO ENROLL IN THE MERCK ACCESS PROGRAM, 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.

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 (PA) or Appeals Process

☐ 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

PATIENT INFORMATION

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): _____ (mobile): _____

Email: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____ Preferred Communication: ☐ Phone ☐ Email ☐ Mail

INSURANCE INFORMATION

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

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

Prior Authorization approval dates: _____

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 #: _____

Patient Name: _____ Date of Birth: _____

PATIENT INFORMATION SECTION

PROGRAM ENROLLMENT & CONSENT TO PROCESS HEALTH INFORMATION

If I am eligible to participate, then by consenting below, I agree to enroll in The Merck Access Program, sponsored by Merck Sharp & Dohme LLC. By choosing to enroll, I agree that The Merck Access Program and the Merck Patient Assistance Program (the "Programs"), Merck Sharp & Dohme LLC, and each of their employees, affiliates, representatives, agents, contractors, and data processors, including the administrators of the Programs (collectively, "Merck"), may collect, use, and disclose health information about me, including the details I provided on this form, information about my participation in the Programs, and other health information about me, such as my diagnosis and medication, to facilitate my participation in the Programs, including, as applicable, to: (i) verify my eligibility to enroll in the Programs and enroll me in the Programs for which I am eligible; (ii) coordinate my benefits and access to my Merck medication, provide reimbursement support, and administer the Programs; (iii) ensure compliance with laws and the rules of the Programs; and (iv) facilitate related internal business purposes, such as to provide customer support and evaluate and improve the Programs. I also agree that Merck may contact me via telephone, email or mail using the contact information I provided on this form for purposes related to the Programs.

I understand that I am not required to consent to this processing of my health information. However, if I do not consent, I will not be able to participate in the Programs, as the processing of my health information is necessary for Merck to facilitate my participation in the Programs.

If I consent, I have the right to withdraw my consent at any time by calling 855-404-5278, by mailing The Merck Access Program, PO Box 2349, Columbus, OH 43216, or via web at merckaccessprogram-prevymis.com/hcc/enroll-now/. For more information about Merck's privacy practices and for privacy disclosures applicable to residents of certain US states, see our US Supplemental Privacy Notice at msdprivacy.com/us/en/supp-notice/ and our Consumer Health Data Privacy Policy at msdprivacy.com/us/en/chd-policy/.

☐ **I CONSENT** to the terms above and agree to enroll into The Merck Access Program.

☐ **I DO NOT CONSENT** to the terms above.

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

By signing below, I authorize each of my physicians, pharmacies, and health plans to obtain, use, and disclose my protected health information, including the details I provided on this form, information about my participation in The Merck Access Program and the Merck Patient Assistance Program (collectively, the "Programs"), and other health information about me, such as my diagnosis, symptoms, medication, and inferences derived from the same (collectively, "PHI"), to The Merck Access Program, the Merck Patient Assistance Program, Merck Sharp & Dohme LLC, and each of their employees, affiliates, representatives, agents, contractors, and data processors, including the administrators of the Programs (collectively, "Merck"), to facilitate my participation in the Programs, including for the itemized purposes listed below. I also agree that Merck may obtain, use, and disclose my PHI to my physicians, pharmacies, and health plans, to my Legal Representative (if any), as well as to Merck vendors and third parties as appropriate to facilitate my participation in the Programs, including, as applicable, to: (i) verify my eligibility to enroll in the Programs and enroll me in the Programs for which I am eligible; (ii) coordinate my benefits and access to my Merck medication, provide reimbursement support, and administer the Programs; (iii) ensure compliance with laws and the rules of the Programs; and (iv) facilitate related internal business purposes, such as to provide customer support and evaluate and improve the Programs.

By signing this authorization, I also acknowledge my understanding that:

- The PHI disclosed pursuant to this authorization, once disclosed, may no longer be governed by certain federal or state privacy laws and may be subject to re-disclosure. However, I also understand that unless I separately consent to additional uses/disclosures, Merck intends to use and disclose my PHI only for the purposes described in this authorization.
- If I choose not to provide this authorization, that decision will not affect my eligibility for, or receipt of, treatment, including Merck products, or healthcare insurance benefits. However, I understand that I will not be able to receive any assistance from the Programs for which I may be eligible.

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION (*CONTINUED*)

- I may cancel this authorization at any time by calling 855-404-5278, mailing a written request to The Merck Access Program, PO Box 2349, Columbus, OH 43216, or via web at merckaccessprogram-prevymis.com/hcc/enroll-now/. I understand that canceling my authorization will mean that my physicians, pharmacies, and health plans, as well as Merck, may no longer rely on this authorization to 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.
- 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 they have collected about me in accordance with Merck's records retention policy.
- I understand that I am entitled to a copy of my signed authorization and that I can obtain copies by downloading them after submission online or by calling 855-404-5278.

By signing, I certify that I have read and agree to the above Patient Authorization for Disclosure of Health Information.

SIGNATURE OF PATIENT, PARENT, LEGAL GUARDIAN, 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: _____

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

By completing the information and signing below, Patient is requesting to be referred to the Merck PAP for an eligibility determination.

To be eligible for enrollment in the Merck PAP for Program Product, Patient must request referral to the Merck PAP 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.

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.
- Patient does not have an insurance plan or employer that participates in or are involved in any way with an alternative funding program that requires or encourages you to apply to the Merck Patient Assistance Program as a condition, requirement, or prerequisite for coverage of specific Merck medications.

THE MERCK PATIENT ASSISTANCE PROGRAM (MERCK PAP) TERMS AND CONDITIONS (*CONTINUED*)

- 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 Patient Assistance Program is not insurance.

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.

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.

SIGNATURE OF PATIENT, PARENT, LEGAL GUARDIAN, OR LEGAL REPRESENTATIVE _____ **Date:** _____

Name of signing party (please print): _____

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

Patient Name: _____ Date of Birth: _____

PATIENT INFORMATION SECTION

MERCK PAP INCOME VERIFICATION

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)

The Patient must authorize Merck PAP to verify their current gross annual household income (household income before taxes are withdrawn) by either:

☐ OPTION 1: Sending with this application, a COPY of only **ONE** of the following documents showing proof of the household income the Patient provided on the application form:

- Most recent 1040 Federal Tax Form
- One month of pay stubs, prior to the application date
- Social Security Benefits Letter
- Veteran Benefits Statement
- Unemployment Benefit Statement
- Disability Statement
- Pension Letter
- Letter from an employer

If selecting Option 1, include a COPY of only ONE of these documents with your completed, signed, and dated enrollment form. Please do not send an original document.

OR

☐ OPTION 2: Authorizing PAP and other individuals involved in administering the PAP to obtain his/her consumer report and/or other information related to his/her credit report to determine the patient's eligibility to participate in the program. This verification will not affect the patient's credit rating.

I understand the Merck Patient Assistance Program, Inc. (Merck PAP) will verify information about my current gross annual household income in order to ensure I am qualified for this program.

Patient should only sign this section if they are NOT providing one of the proofs of income documents.

By signing below, I am providing written authorization to Merck PAP and other individuals involved in administering the Merck PAP to obtain my consumer report and/or other information related to my credit report to determine my eligibility to participate in the program. This verification will not affect my credit rating.

SIGNATURE OF PATIENT, PARENT, LEGAL GUARDIAN, 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.**

Please remember to complete Healthcare Provider Information Section on the next page.

Patient Name: _____ Date of Birth: _____

HEALTHCARE PROVIDER INFORMATION SECTION

HEALTHCARE PROVIDER INFORMATION (to be completed by healthcare provider)

Anticipated start date of PREVYMIS® (letermovir): _____ **Select one:** ☐ Tablet ☐ Pellet **Dosage:** _____

Healthcare provider name: _____

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

Practice tax ID #: _____ Practice NPI #: _____

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

Phone: _____ **Fax:** _____

Office contact person: _____ **Office contact number:** _____ **Extension:** _____

Email: _____ Preferred Communication: ☐ Phone ☐ Fax ☐ Email

HEALTHCARE PROVIDER ATTESTATION

I represent and warrant that I or others in my practice ("my Practice") have obtained written authorization from the patient listed above (the "Patient") that complies with the HIPAA Privacy Rule, authorizes me, my Practice, and the Patient's health insurance plan(s), to disclose the Patient's protected health information ("PHI") to The Merck Access Program and the Merck Patient Assistance Program (together, "the Programs"), Merck Sharp & Dohme LLC, and each of their employees, affiliates, representatives, agents, contractors, and data processors, including the administrators of the Programs (collectively, "Merck"), and authorizes Merck to use and disclose the PHI for purposes of the Programs, including to provide benefits investigation and reimbursement support, and for Merck's related internal business purposes. If my Practice uses a Third-Party Administrator (TPA), I represent and warrant that the TPA is authorized to submit enrollment forms to Merck on my behalf, has been trained on the Merck Programs' rules and requirements, and will not sign any documents on behalf of the Patient. I represent and warrant that I am authorized under the laws of my state of license to prescribe PREVYMIS, that I have determined that PREVYMIS is medically appropriate for the Patient, and that I will supervise the Patient's treatment. I certify that the Program Product is being used in an outpatient setting only. If the Patient receives PREVYMIS through the Merck PAP, neither I nor my Practice will receive any reimbursement from Merck, whether for administration fees or otherwise 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. 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.

By signing, I certify that I have read and agree to the above Healthcare Provider Attestation and the information provided is complete and accurate to the best of my knowledge.

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