The Merck Access Program
Enrollment Form

EMEND® (aprepitant) for oral suspension 125 mg

Phone: 855-257-3932, Fax: 855-755-0518 • The Merck Access Program, PO Box 29067, Phoenix, AZ 85038

TO GET STARTED, COMPLETE THE ENROLLMENT FORM AND FAX IT TO 855-755-0518. IF REQUESTING A REFERRAL TO THE MERCK PATIENT ASSISTANCE PROGRAM, PLEASE INCLUDE A PRESCRIPTION FOR EMEND.

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

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

PATIENT INFORMATION SECTION

PATIENT INFORMATION (to be completed for all patients)

Patient is a US resident: ☐ Yes ☐ No Sex: ☐ M ☐ F

Patient name:_____ Date of birth:_____

Address:_____ City/state/zip:_____

(Please provide a street address only, no PO boxes.)

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

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.

Name of personal representative:_____

Phone (home):_____ (cell):_____ (work):_____

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 Corp. ("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 their administrators, 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 numbers, e-mail address, and/or text number listed above for that purpose.

Print name:_____

Signature:_____ Date:_____

PATIENT INFORMATION SECTION

INSURANCE INFORMATION (to be completed for all patients)

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:** ☐ **Part A** ☐ **Part B** ☐ **Part D** ☐ **Medicare Advantage**

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

Plan name and state:_____

Phone number for customer service:_____ Name of policyholder:_____

Policyholder date of birth:_____ Policyholder relationship to patient:_____

Group no.:_____ Policy ID no.:_____

Secondary/supplemental insurer

Plan name and state:_____

Phone number for customer service:_____ Name of policyholder:_____

Policyholder date of birth:_____ Policyholder relationship to patient:_____

Group no.:_____ Policy ID no.:_____

Prescription/Medicare Part D insurer

Plan name and state:_____

Phone number for customer service:_____ Name of policyholder:_____

Policyholder date of birth:_____ Policyholder relationship to patient:_____

Group no.:_____ Policy ID no.:_____

REQUIRED FOR THE MERCK PATIENT ASSISTANCE PROGRAM

Current annual gross household income: $_____
(Please include: before-tax wages, pension, interest/dividends, Social Security benefits, and any other sources of income)

Number of household members (including patient):_____

PATIENT AUTHORIZATION

I understand that, before I may have communications with The Merck Access Program, sponsored by Merck Sharp & Dohme Corp. ("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 (i) 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; and (ii) Covance Market Access ("Covance") and its administrators, contractors, representatives, or third-party service partners to provide reimbursement support and to investigate insurance coverage in connection with The Merck Access Program.

PATIENT AUTHORIZATION (*continued*)

I also authorize the administrators of the Programs and Covance, 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 Covance 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, Covance, their contractors, representatives or third-party service 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 service 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 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 health care 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) 257-3932 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 Covance 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, parent, legal guardian, or legal representative:_____ Date: _____

Name of signing party (please print):_____

If legal representative, relationship of legal representative to patient:_____

PATIENT INFORMATION SECTION

THE MERCK PATIENT ASSISTANCE PROGRAM (provided through the Merck Patient Assistance Program, Inc.)

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 the 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 health care provider 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.

PATIENT ACKNOWLEDGMENT AND SIGNATURE

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):_____

HEALTH CARE PROVIDER INFORMATION SECTION

HEALTH CARE PROVIDER INFORMATION (to be completed by health care provider)

Health care provider name:_____ Health care provider tax ID no.:_____

Health care provider NPI no.:_____

Health care provider State license no.: _____ Health care provider State license no. expiration date: _____

Address:_____ City/state/zip: _____
(Please provide a street address only, no PO boxes.)

Phone:_____ Fax:_____

Office contact person:_____ Office contact number:_____

Practice/Facility name:_____

Practice tax ID no.:_____ Practice NPI no.:_____

Practice/Facility address:_____ City/state/zip: _____

Please list all applicable diagnosis codes:_____

HEALTH CARE PROVIDER ATTESTATION (to be completed by health care provider)

MUST CONTAIN ORIGINAL SIGNATURE

By signing below, I represent and warrant the following:

- This Enrollment Form has been prepared exclusively by the health care provider or health care provider office identified in this Enrollment Form ("my Practice").
- My Practice has 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 Covance Market Access, and authorizes the Programs and Covance Market Access (together with their respective administrators, contractors or other affiliates) to use and disclose the PHI for purposes of benefits investigation and reimbursement support.
- I certify that I, or a health care provider in my Practice, have determined that the prescribed product is medically appropriate for the patient identified above and that I, or a health care provider in my Practice, will be supervising the patient's treatment.
- I certify that I am authorized, pursuant to the laws of my state of licensure, to prescribe EMEND® (aprepitant).
- 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 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, excluding patient-identifiable data (unless the auditor enters into an appropriate agreement with my Practice to protect an individual's medical privacy).
- I consent to receive communications related to the Program by telephone, e-mail, and/or fax.
- 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.

HEALTH CARE PROVIDER SIGNATURE

Health care provider original signature:_____ Date:_____

Health care provider name (please print):_____ License no.: _____

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

Is health care provider licensed in Vermont? ☐ Yes ☐ No If yes, provide Vermont license no.:_____

To report an adverse event to a specific Merck Product, including death due to any cause, please contact the Merck National Service Center at 1-800-444-2080.

MERCK