MERCK VACCINE PATIENT ASSISTANCE PROGRAM APPLICATION

IMPORTANT: A dose of Merck vaccine must not be administered until after the Merck Vaccine Patient Assistance Program provides a confirmation number. This includes subsequent doses in a multidose series because a new application for each dose is required. Doses of vaccine administered before application submission and/or receipt of a confirmation number will not be replaced.

SECTION 1: APPLICANT INFORMATION *(Patient should complete all information in Section 1.)*

Patient's First Name | US Resident* ☐ Yes ☐ No

*You do not need to be a US citizen.

Last Name

Address | Apt. No.

City | State | Zip

Phone | Date of Birth (M M D D Y Y Y Y) | Gender ☐ Male ☐ Female ☐ Other Identity

Do you have Medicare insurance?	Yes ❑	No ❑
Medicare beneficiaries only: Do you have Medicare Part D?	Yes ❑	No ❑
Do you have any other health insurance coverage of any kind *(public or private)*?	Yes ❑	No ❑
Examples: *Medicaid, veterans benefits, health maintenance organization (HMO), preferred provider organization (PPO), college health plan, federal or state insurance, or health assistance program*		
Are you covered under another individual's health insurance plan?	Yes ❑	No ❑
Are you claimed as a dependent on another individual's tax return?	Yes ❑	No ❑

Current gross annual household income (income before taxes): $_____

Number in household who are dependent on the household's income (including applicant): _____

Please read the *Applicant Declarations* and sign the section to indicate your agreement.

APPLICANT DECLARATIONS

I certify that all of the information provided by me in this application, including household income, is complete and accurate. I understand that Merck is not responsible for checking or verifying any information contained in Section 2 of this application and that only the licensed prescriber will be responsible for accuracy of the information contained in Section 2. I understand that assistance from the Merck Vaccine Patient Assistance Program (PAP) will terminate if the PAP becomes aware of any fraud or if the vaccine covered by the PAP is no longer indicated for me. I understand that completing this application does not ensure that I will qualify for the PAP. I certify that I cannot afford to pay for this vaccine myself. I certify that I will not seek reimbursement or credit for this vaccine 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 this vaccine or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs. I understand that the PAP reserves the right to modify the application form, modify or discontinue this program, or terminate assistance at any time and without notice. I understand that the PAP reserves the right to conduct periodic audits and to require additional documentation from me to verify the information provided in this application. I understand that assistance received through the PAP is not insurance.

SIGN **Patient's Original Signature:**_____ **Date:**_____

Patient name (first, last) _____

Please read the *Applicant Authorization* and sign the section to indicate your agreement.

APPLICANT AUTHORIZATION

By signing below, I authorize my health care provider(s) and health plans, including Medicare, to disclose to the Merck Vaccine Patient Assistance Program and other individuals involved in administering the Merck Vaccine Patient Assistance Program (collectively, the "PAP") my personal health information, including the information provided by my health care provider on the PAP Application form and other information related to my participation in the PAP (collectively, "My Information"), so that the PAP may use the information to (i) assess my qualification for the PAP, (ii) provide me with PAP assistance, (iii) administer the PAP, and (iv) monitor, audit, access, and evaluate the PAP's implementation and effectiveness. I authorize the PAP to use and disclose My Information for the foregoing purposes, including to make disclosures to PAP affiliates and contractors and to my health plans, including Medicare, and to contact me as part of PAP audits and to request additional information from me. I understand that My Information, once disclosed pursuant to this authorization, may no longer be protected by federal law and could be re-disclosed to others, but I also understand that the PAP intends to safeguard My Information and to use and disclose it only for the purposes herein. I understand that I do not need to sign this Authorization in order to receive health care treatment or insurance benefits, but that if I do not sign the Authorization, I will not be able to obtain assistance from the PAP. I further understand that I may cancel the Authorization at any time by sending a written notice of cancellation by mail to: Merck Vaccine Patient Assistance Program, PO Box 690 Horsham, PA 19044-9979. I understand that if I cancel the Authorization, that will not invalidate uses and disclosures of My Information made before the PAP received notice of my cancellation. If I do not cancel it, the Authorization will remain in effect for 15 months from the date signed below (or the maximum period allowed by applicable state law, if less than 15 months). I have read this document or have had it explained to me. I understand that I may request a copy of this Authorization once it has been signed.

Patient Signature

SIGN

_____	_____	_____
Name of Patient	Signature	Date
_____	_____	_____
Name of Legal Representative	Signature	Date

If signed by Legal Representative, describe the nature of relationship with patient:

_____

NOTE to Health Care Provider: Patient and HCP complete all sections before submitting (or faxing) for eligibility review.

Patient name (first, last) _____

SECTION 2: LICENSED PRESCRIBER INFORMATION *(Health care provider should complete Sections 2 and 3.)*

First, Last Name

Practice/Clinic Name

Address Ste/Flr

City State Zip

Note: The address you provide above is where Merck will ship the replacement dose.

Type of Licensed Prescriber: ❑ Physician ❑ Nurse Practitioner ❑ Physician Assistant ❑ Certified Nurse Midwife

State License Number: #_____ (must be active and valid)

Date of Expiration: _____

Office Contact Person: _____

Phone Number: _____ Fax Number: _____

Facility Delivery Hours (day/times): _____

SECTION 3: VACCINE INFORMATION

Merck Vaccine Product Name: _____ NDC Number: #_____

Please indicate the enrolling patient's Dose Number for this Merck Vaccine: ❑ Dose #**1** ❑ Dose #**2** ❑ Dose #**3**

Have you already administered this dose? Yes ❑ No ❑

Merck will replace the doses of vaccine administered to approved patients via monthly shipments to the licensed prescriber. *[Notes: Merck retains the right to select either prefilled syringes or vials for replacement doses which may or may not be the same as what was administered to approved patients.]*

To be completed after application is approved by a Merck Vaccine Patient Assistance Program Representative

Confirmation Number: #_____

Date of Administration: _____/_____/_____ **Merck Vaccine Lot Number: #**_____

IMPORTANT: The confirmation number is valid for **30 days**. If the vaccine dose is not administered to the eligible patient within 30 days following when it was granted, the patient must submit a new application. The office must provide the date of administration and lot number to the Merck Vaccine Patient Assistance Program for all approved doses of vaccine in order for replacement product to be provided.

LICENSED PRESCRIBER DECLARATIONS

I verify that the information provided on this application is complete and accurate. I understand that the patient must be part of the population for which the administered vaccine is indicated and I certify that this vaccine is medically indicated for this patient. I understand that the patient must qualify financially and meet the program criteria to be eligible for assistance. The product administered to the above patient on the date(s) above will be considered a donation to the patient from the Merck Vaccine Patient Assistance Program. I also understand that the product I receive is not a sample, but a replacement of product I previously purchased. I understand that I will not receive any reimbursement from Merck & Co., Inc., whether for administration fees or otherwise. I will not seek reimbursement for administration of vaccine from any public payer. Additionally, reimbursement for the cost of the product administered to the above patient on the date(s) above has not been sought and will not be sought from any source.

I understand that Merck & Co., Inc., reserves the right to conduct periodic audits of the records of all entities receiving replacement of inventory in connection with the Merck Vaccine Patient Assistance Program. I accept that reasonable notice will be granted and audits will be conducted during regular business hours. I represent and warrant that this facility has obtained all applicable authorizations, consents, and notices necessary to comply with all federal and state laws and regulations relating in any way to medical and/or health privacy including but not limited to the HIPAA Privacy Rule, codified at 45 C.F.R. Parts 160 and 164, as amended from time to time.

My signature below confirms that the vaccine product will be provided free of charge to this individual. I verify that to the best of my knowledge the information set forth in this application is complete and accurate. I agree to retain a copy of this form in the facility's records and to make it available to the Internal Revenue Service upon request.

SIGN **Licensed Prescriber's Original Signature:** _____ **Date:** _____

(No stamps accepted)

FAX ALL PAGES OF APPLICATION TO 800-528-2551