

THE MERCK ACCESS PROGRAM ENROLLMENT FORM



Please read the accompanying **Medication Guide** for WELIREG, including an important warning about harm to an unborn baby, and discuss it with your doctor. The physician **Prescribing Information** also is available.

Phone: 855-257-3932 Fax: 855-755-0518 • The Merck Access Program, PO Box 2349, Columbus, OH 43216

Prescriptions for WELIREG can be filled through EITHER the specialty pharmacy network or certain physician practices with dispensing capabilities and certain hospital pharmacies. Please select the appropriate option below for how your patients can obtain WELIREG.

Specialty Pharmacy Network



Option 1: If a specialty pharmacy has referred your patient to The Merck Access Program (MAP) to determine eligibility for the Merck Patient Assistance Program (PAP), please select which pharmacy made the referral:

☐ Biologics Pharmacy ☐ Onco360 Oncology Pharmacy

Please complete sections 2–10, as applicable, to have your patient referred to the Merck PAP for eligibility determination.

Certain Physician Practices With Dispensing Capabilities & Certain Hospital Pharmacies



Option 2: If your facility is dispensing WELIREG, please check all boxes below that apply:

- ☐ Patient Benefit Investigation and/or information about the Prior Authorization or Appeals Process
- ☐ Referral to the Merck PAP for eligibility determination (provided through the Merck Patient Assistance Program, Inc.)

Please complete sections 1–10, as applicable, to enroll your patient in The Merck Access Program (MAP).

Section 1: Insurance Information

INSURANCE INFORMATION (REQUIRED)

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

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

Please include a copy of the PA Approval (if available). PA Approval Dates: _____

☐ Patient has no insurance

☐ Patient has insurance through Medicare: ☐ Yes ☐ No

(If yes): ☐ Part A ☐ Part B ☐ Part D ☐ Medicare Advantage

	PRIMARY INSURANCE	SECONDARY INSURANCE
PLAN NAME AND STATE		
NAME OF POLICYHOLDER		
POLICYHOLDER DATE OF BIRTH		
POLICYHOLDER RELATION TO PATIENT		
PHONE NUMBER FOR CUSTOMER SERVICE		
GROUP NO.		
POLICY ID NO.		

Section 2: Patient Information

PATIENT INFORMATION

Patient is a US resident: ☐ Yes ☐ No Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

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

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

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

Email: _____

Section 3: Program Enrollment and 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) 257-3932, by mailing The Merck Access Program, PO Box 2349, Columbus, OH, 43216, or via web at [merckaccessprogram-welireg.com/hcc/merck-patient-assistance-program/](https://www.merckaccessprogram-welireg.com/hcc/merck-patient-assistance-program/). 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 <https://www.msdprivacy.com/us/en/supp-notice/> and our Consumer Health Data Privacy Policy at <https://www.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.

Section 4: 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.

THE MERCK ACCESS PROGRAM PHONE: 855-257-3932, FAX: 855-755-0518

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.
- I may cancel this authorization at any time by calling (855) 257-3932, mailing a written request to The Merck Access Program, PO Box 2349, Columbus, OH, 43216, or via web at merckaccessprogram-welireg.com/hcc/merck-patient-assistance-program/. 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) 257-3932.

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

PATIENT SIGNATURE



Signature of patient 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: _____

Section 5: The Merck Patient Assistance Program (Merck PAP) Terms and Conditions

To be eligible for enrollment in the Merck PAP for the Program Product, Patient must request referral to the Merck PAP (see checkbox on page 1) 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 is 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.
- 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, certain physician practices, or certain hospital pharmacies 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.

Section 6: 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.

Section 7: 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.

PATIENT SIGNATURE

Signature of patient or legal representative: _____ Date: _____

Name of signing party (please print): _____

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

Section 8: 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 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 | – Social Security Benefits Letter | – Disability Statement |
| – One month of pay stubs, prior to the application date | – Veteran Benefits Statement | – Pension Letter |
| | – Unemployment Benefit Statement | – 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. No signature is required.

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.

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.

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

PATIENT SIGNATURE

Signature of patient or legal representative: _____ Date: _____

Name of signing party (please print): _____

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

Section 9: Healthcare Provider Information

HEALTHCARE PROVIDER INFORMATION (to be completed by healthcare provider)

Healthcare provider name: _____

Healthcare provider tax ID no.: _____ Healthcare provider NPI no.: _____

Address: _____ City/state/zip: _____

(Street address only, no PO boxes)

Practice/Facility name: _____ Practice tax ID no.: _____

Practice NPI no.: _____

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

(Street address only, no PO boxes)

Phone: _____ Ext: _____ Fax: _____

Office contact person: _____ Office contact number: _____ Ext: _____

Email: _____

Product use is consistent with labeled indications for WELIREG® (belzutifan): ☐ Yes ☐ No

Section 10: Healthcare Provider Attestation

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 WELIREG, that I have determined that WELIREG 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 WELIREG 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.

Section 10: Healthcare Provider Attestation *(continued)*

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

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.



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THE MERCK ACCESS PROGRAM PHONE: 855-257-3932, FAX: 855-755-0518