THE MERCK ACCESS PROGRAM

PATIENT ENROLLMENT FORM

WELIREG™ (belzutifan) 40 mg tablets

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

To get started, complete the patient enrollment form.
Your healthcare provider must also submit a healthcare provider enrollment form, found at www.merckaccessprogram-welireg.com/hcp.

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

☐ 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

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

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

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

Email: _____

Section 3: Patient Authorization

PATIENT AUTHORIZATION

I understand that, before I may have communications with The Merck Access Program, sponsored by Merck Sharp & Dohme LLC ("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) Merck and the Programs; (ii) the administrators of the Programs, their contractors, third-party service providers, and representatives (collectively, "Program Administrators"); and (iii) the administrator of Merck's field access and reimbursement support team, its contractors, representatives, and third-party services partners (collectively, the "Field Access and Reimbursement Support Administrator") in order to (i) verify my eligibility to enroll in the Programs; (ii) enroll me in the Programs for which I am eligible; (iii) provide reimbursement support; and (iv) investigate insurance coverage in connection with The Merck Access Program.

I also authorize Merck, the Programs, the Program Administrators, and Field Access and Reimbursement Support Administrator, and their respective contractors to use, share, and disclose my PHI for the following purposes: (i) to provide the services described in this enrollment form; (ii) to communicate with me by U.S. postal mail, telephone, text, or email; (iii) to prepare summaries that do not include my PHI for statistical purposes; (iv) to conduct analyses to help Merck evaluate, improve, and/or provide its services, customer support, and educational and/or promotional materials for patients prescribed Merck medications; and (v) to 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 Program Administrators and Field Access and Reimbursement Support Administrator to disclose my PHI to authorized representatives of Merck and the Programs 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 Program Administrators, Field Access and Reimbursement Support Administrator, my physicians, pharmacies, and me for compliance purposes.

PATIENT AUTHORIZATION

If I have designated a Legal Representative, I authorize Merck, the Programs, Program Administrators, and Field Access and Reimbursement Support Administrator to use my PHI to contact the person I have designated as my Legal 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 to my Legal Representative for the purposes described in this authorization.

I understand that the PHI disclosed pursuant to this authorization, once disclosed, may not be governed by the same privacy laws 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 healthcare 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 2349, Columbus, OH 43216. I understand that canceling my authorization will mean that my physicians, pharmacies, and health plans, as well as the Field Access and Reimbursement Support Administrator, Merck, the Programs, and the Program Administrators 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 and may request a copy by contacting The Merck Access Program at the contact information provided above.

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 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 4: The Merck Patient Assistance Program (Merck PAP) Terms And Conditions

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

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.

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.)

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.
- 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 5: 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 6: 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 7: Merck PAP Income Verification

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

a. OPTION 1: 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.

OR

b. OPTION 2: 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 2, include a COPY of only **ONE** of these documents with your completed, signed, and dated enrollment form. Please do not send an original document.

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 SIGNATURE

Signature of patient or legal representative: _____ **Date:** _____

Name of signing party (please print): _____

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

MERCK