

# 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 29067, Phoenix, AZ 85038

**Complete the Enrollment Form and submit online, or print and fax the completed downloadable form to 855-755-0518. If requesting a referral to the Merck Patient Assistance Program (PAP), please include a prescription for WELIREG.**

Complete the information below only if using one of the network specialty pharmacies to obtain WELIREG. If you are obtaining WELIREG through a Merck-authorized, provider-owned specialty pharmacy, please fill out the next section below.

## Obtaining WELIREG through the specialty pharmacy network

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

- Onco360 Oncology Pharmacy  Biologics Pharmacy

**Please complete sections 2–7, as applicable, to have your patient referred to the Merck PAP for eligibility determination.**

## Obtaining WELIREG through the Merck-authorized, provider-owned specialty pharmacy network

**Option 2: If your facility has been authorized by Merck to dispense WELIREG, please check all boxes below that apply and complete sections 1–7, as applicable, to enroll your patient in The Merck Access Program (MAP).**

- 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 be sure to send a prescription for WELIREG.

Check off the box for the selected specialty pharmacy.

Complete the information below only if using a Merck-authorized, provider-owned specialty pharmacy network. If you are obtaining WELIREG through one of the above specialty pharmacies, please fill out the previous section.

Check off the relevant box(es).

## 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

Complete the information for the patient's insurance and supplemental insurance (if applicable). Include a copy of the front and back of any insurance card(s).

If the patient has insurance through Medicare, check off the appropriate Medicare plan(s).

### 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/yy): \_\_\_\_\_

Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Please be sure that the plan name and policy ID number match what is on the patient's ID card.

### 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/yy): \_\_\_\_\_

Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

## Section 2: Patient Information

Fill out patient information completely.

### PATIENT INFORMATION

Patient is a US resident:  Yes  No

Check off the box applicable to the patient.

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: \_\_\_\_\_

### REQUIRED FOR THE MERCK PATIENT ASSISTANCE PROGRAM

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 should complete this section if requesting a referral to the Merck Patient Assistance Program.

## 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 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.

I also authorize the administrators of the Programs and their contractors or representatives to (i) use my PHI to provide the services described in this enrollment form, including to communicate with me by US postal mail, telephone, text, or email 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.

**PATIENT AUTHORIZATION**

I also authorize the administrators of the Programs 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, their contractors, representatives or third-party services 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 services 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 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 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): \_\_\_\_\_

Relationship to patient (if other than patient signing): \_\_\_\_\_

The patient or representative must sign here.

Date is required.

## Section 4: The Merck Patient Assistance Program

### 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 the 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 the 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 the Merck PAP and its affiliates to forward the prescription to a dispensing pharmacy on my behalf. The Merck PAP is not acting as a dispensing pharmacy. The 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 physician who will be supervising my treatment, to verify the information provided herein.

I understand that assistance received through the Merck PAP is not insurance.

If another person will be legally signing on behalf of the patient or if the patient would like to designate a person to act on his or her behalf to verify information and coordinate provisions of the programs described in this enrollment form, PLEASE INCLUDE A COMPLETED REPRESENTATIVE'S FORM WITH THIS ENROLLMENT FORM.

**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, parent, legal guardian, or legal representative: \_\_\_\_\_ Date: \_\_\_\_\_

Name of signing party (please print): \_\_\_\_\_

Relationship to patient (if other than patient signing): \_\_\_\_\_

Check off the box applicable to the patient.

- Patient has no insurance  
 Patient has insurance

The patient or representative must sign here.

Date is required.

## Section 5: Merck PAP–Patient Attestation of Hardship

### MERCK PAP–PATIENT ATTESTATION OF FINANCIAL HARDSHIP

The Merck PAP is designed primarily for individuals who do not have prescription drug or health insurance coverage; however, individuals with insurance coverage may still request assistance if they experience a financial hardship (ie, the individual cannot afford the deductible, co-pay, co-insurance, or other cost-sharing requirement of his or her insurance plan). If you would like to be considered for an exception to the Merck PAP's insurance criteria, please carefully review the attestations below and sign and date this section.\*

\*The Merck PAP evaluates all requests for an exception to its insurance criteria based on a financial hardship on a case-by-case basis, and cannot guarantee that an exception will be made.

1. I attest that the information provided in this enrollment form is complete and accurate. If my Benefit Investigation determines that my insurance does not fully cover my prescription cost, I would like to be considered for a financial hardship exception to the Merck PAP's insurance criteria. I understand that the determination of whether to approve a financial hardship exception resides exclusively with the Merck PAP.
2. I understand that if I have Medicare coverage, my eligibility will automatically expire on December 31 of the current calendar year and it will be necessary for me to submit a new application before December 31 for program determination of eligibility for the following year. If I fail to re-enroll before December 31, I understand that I will no longer receive my medication from the Merck Patient Assistance Program.

**I have Medicare Part D coverage** (please check applicable box)

Yes  No

3. I understand that if I have private prescription drug coverage, my eligibility will automatically expire 1 year from my date of enrollment and I must re-enroll for program determination of eligibility for the following year.
4. I attest that I will notify the Merck Patient Assistance Program immediately if anything changes with my prescription or my insurance coverage.
5. I understand that the Merck Patient Assistance Program reserves the right to request additional documentation from me to support my request for an exception based on my financial hardship including, for example, documents relating to my income.

I understand it is my responsibility to promptly inform the Program of any information that changes from what is being submitted on this form.

**PATIENT SIGNATURE**

Signature of patient, parent, legal guardian, or legal representative: \_\_\_\_\_ Date: \_\_\_\_\_

Name of signing party (please print): \_\_\_\_\_

Relationship to patient (if other than patient signing): \_\_\_\_\_

The patient or representative must sign here.

Date is required.

## Section 6: Healthcare Provider Information

Please fill out the following fields as applicable for the healthcare provider.

### HEALTHCARE PROVIDER INFORMATION (to be completed by healthcare provider)

Healthcare provider name: \_\_\_\_\_

Healthcare provider tax ID #: \_\_\_\_\_ Healthcare provider NPI #: \_\_\_\_\_

Healthcare provider State license #: \_\_\_\_\_

Healthcare provider State license # expiration date: \_\_\_\_\_

Practice/Facility name: \_\_\_\_\_ Practice tax ID #: \_\_\_\_\_

Practice NPI #: \_\_\_\_\_

Address: \_\_\_\_\_ City/state/zip: \_\_\_\_\_

(Street address only, no PO boxes)

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Office contact person: \_\_\_\_\_ Office contact number: \_\_\_\_\_

Include the email address of the office contact person.

Email: \_\_\_\_\_

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

### MERCK-AUTHORIZED, PROVIDER-OWNED SPECIALTY PHARMACY INFORMATION (only complete if your facility has been approved to dispense WELIREG™ [belzutifan])

Pharmacy name: \_\_\_\_\_ Pharmacy address: \_\_\_\_\_

Pharmacy phone: \_\_\_\_\_ Pharmacy contact person: \_\_\_\_\_

Pharmacy fax: \_\_\_\_\_ Pharmacy contact email: \_\_\_\_\_

Pharmacy contact phone: \_\_\_\_\_

## Section 7: Healthcare Provider Attestation

### HEALTHCARE PROVIDER ATTESTATION

By signing below, I represent and warrant the following:

- This Enrollment Form has been prepared exclusively by the healthcare provider or healthcare provider office identified in this Enrollment Form.
- By signing below, I represent and warrant that I am authorized pursuant to the laws of my state of license to prescribe WELIREG.

HEALTHCARE PROVIDER ATTESTATION

- I or others in my healthcare provider practice group (“my Practice”) have 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 my 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 authorizes the Programs, including their contractors or other affiliates, to use and disclose the PHI for purposes of benefits investigation and reimbursement support.
- I certify that I, or a healthcare provider in my Practice, have determined that the prescribed product is medically appropriate for the patient identified above and that I, or a healthcare provider in my Practice, will be supervising the patient’s treatment.
- 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 administrative 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 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.
- I understand that the Programs reserve the right to modify or discontinue this program at this facility/practice, or terminate assistance at any time and without notice.
- 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.

HEALTHCARE PROVIDER SIGNATURE

Healthcare provider signature: \_\_\_\_\_ Date: \_\_\_\_\_

Healthcare provider name (please print): \_\_\_\_\_

Healthcare provider designation (MD, DO, NP, PA, other): \_\_\_\_\_

Is healthcare provider licensed in Vermont?  Yes  No. If yes, provide Vermont License #: \_\_\_\_\_

The healthcare provider must sign here.

Date is required.

Select whether the healthcare provider is licensed in the state of Vermont.

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



Copyright © 2022 Merck & Co., Inc., Rahway, NJ, USA and its affiliates. All rights reserved. US-BEL-00498 08/22

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