

How Can I Submit My Completed Application?



FAX 1-800-528-2551

How Can We Help?

For inquiries, please
call 1-800-293-3881

PROGRAM INFORMATION

As part of our commitment to Patients, the Merck Patient Assistance Program, Inc. (Merck PAP) provides certain Merck adult vaccines free of charge to eligible Patients who lack third-party coverage and cannot afford to pay for them.

Applying to Merck PAP is FREE. Merck PAP is not associated with any individuals or organizations who may charge Patients a fee to assist them in completing enrollment forms for Merck PAP. These individuals or organizations are acting independently of Merck PAP and do not have Merck PAP's consent.

To be eligible for Merck PAP, both the Patient AND the Prescribing Healthcare Professional must complete, sign, and date this Merck Vaccine Patient Assistance Program (PAP) application form and certify that:

1. A Healthcare Provider has prescribed the Patient a Merck vaccine covered by the PAP and will use their own vaccine inventory to administer the vaccine.
2. The Patient currently resides in the United States (US) or US Territory (the Patient does not need to be a US citizen) and is aged 19 or older.
3. The 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 Vaccine Patient Assistance Program as a condition, requirement, or prerequisite for coverage of specific Merck vaccines. Examples of health insurance include:
 - a. Employer-provided or private insurance
 - b. Health Maintenance Organizations (HMOs)
 - c. Medicaid or Medicare
 - d. Veterans assistance or any other social service agency support
4. The Patient cannot afford to pay for the Merck vaccine and PAP can verify the Patient meets the Program's financial eligibility criteria. Information about specific financial criteria levels is available by visiting MerckHelps.com or calling 1-800-293-3881.
5. For the most current list of Merck vaccines available through this Program, please visit MerckHelps.com, or call the Merck Vaccine Patient Assistant Program at 1-800-293-3881. Patient advocates are available to assist you Monday through Friday, 8 AM to 8 PM ET.

PROGRAM CHECKLIST

1. Check your eligibility at MerckHelps.com.
2. Both the Patient and the Prescribing Healthcare Professional must complete all sections of this form.
3. Both the Patient and the Prescribing Healthcare Professional must check, sign, AND date this form in all designated places.
4. The enrollment form must be completed, submitted by fax, and approved PRIOR to the administration of the Merck vaccine to qualify.
 - a. Some vaccines require more than one dose. A new enrollment form must be completed, submitted, and approved before a Patient can receive each dose in the regimen.

NOTE: PAP intends to process enrollment forms in 10 minutes or less after receiving a completed enrollment form. A completed form must have all fields filled-in, all signature fields completed, the consent box checked, and the Patient's income authorization or supporting income documentation. Healthcare Professionals will be notified by phone if the Patient is determined eligible to receive the Merck vaccine for facility replacement. We understand that Patients who verify income eligibility using one of the documents listed on page 4 of this application may have to return to the healthcare facility with documentation in order to complete and fax their application and supporting income documents.

Patients who do not meet income eligibility based on their consumer report may resubmit their application using any one of the documents listed on page 4 of this application.



Scan to learn more about Merck's Patient Assistance Programs or find out more at MerckHelps.com.

DO NOT INCLUDE THIS COVER PAGE WHEN FAXING THE COMPLETED AND SIGNED ENROLLMENT FORM.

SECTION 1: PATIENT INFORMATION

IMPORTANT: Do not administer any Merck vaccine until AFTER the Merck Vaccine Patient Assistance Program (PAP) has provided you with the PAP confirmation number. PAP will not be able to replace doses administered BEFORE application submission and/or confirmation. For multi-dose series, a new PAP application and confirmation number are required for each dose.

Patient's First Name

Patient's Last Name

Date of Birth (MM/DD/YYYY)

Address Line 1

Address Line 2 (Apartment/Unit Number)

Resident in the US
or a US Territory:☐

Yes

☐

No

*You do not have
to be a US citizen*

City

State

Zip

Gender:

☐

Male

☐

Female

☐Other
Identity

Phone Number

Do you have insurance or other prescription drug coverage?

☐

Yes

☐

No

Are you enrolled in any of the following?

☐

Medicare Part A or B

☐

Medicare Part D

☐

Medicaid

☐Employer-Provided
Insurance or Private
Insurance☐

Other

If Other, Please Describe

Consent to Process Personal and Sensitive Information for Merck PAP Purposes

If I am eligible to participate, then by consenting below, I agree to enroll in the Merck Patient Assistance Program Inc. (the "Program"). By choosing to enroll, I agree that the Program and its employees, affiliates, representatives, agents, contractors, and data processors, including the administrators of the Program (collectively, the "Merck PAP"), may collect, use, and disclose personal and sensitive personal information about me, including the details I provided on this form, information about my participation in the Program, and other health information about me, such as my diagnosis, symptoms, medication, and inferences derived from the same, to facilitate my participation in the Program, including, as applicable, to: (i) assess my eligibility to enroll in the Program; (ii) provide me with Merck PAP assistance; (iii) administer the Merck PAP; and (iv) monitor, audit, access, and evaluate the Merck PAP's implementation and effectiveness. I also agree that Merck PAP may contact me via text, phone, or mail using the contact information I provided on this form for purposes related to the Program, including to send me information about my vaccine.

I understand that I am not required to consent to the processing of my information. However, if I do not consent, I will not be able to participate in the Program, as the processing of my information is necessary for the Merck PAP to facilitate my participation.

If I consent, I have the right to withdraw my consent at any time by calling 1-800-293-3881, by mailing Merck Patient Assistance Program, PO Box 1206, Wilkes Barre, PA 18703-1206, or via fax at 1-800-528-2551. 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.msprivacy.com/us/en/supp-notice/> and our Consumer Health Data Privacy Policy at <https://www.msprivacy.com/us/en/chd-policy/>.

CHECK
HERE☐I **CONSENT** to the terms above.☐I **DO NOT CONSENT** to the terms above.

SECTION 2: PATIENT AUTHORIZATION

Patient Authorization for Use and Disclosure of Protected Health Information

By signing below, I authorize my healthcare provider(s) and health plans, including Medicare, to disclose to the Merck PAP and other individuals involved in administering the Merck PAP my personal health information, including the information provided by my healthcare provider on the Merck PAP Application form and other information related to my participation in the Merck PAP (collectively, "My Information"), so that the Merck PAP may use the information to: (i) assess my qualification for the Merck PAP; (ii) provide me with Merck PAP assistance; (iii) administer the Merck PAP; and (iv) monitor, audit, access, and evaluate the Merck PAP's implementation and effectiveness. I authorize the Merck PAP to use and disclose My Information for the foregoing purposes, including to make disclosures to Merck PAP affiliates and contractors and to my health plans, including Medicare, and to contact me as part of Merck 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 Merck 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 healthcare treatment or insurance benefits, but that if I do not sign the Authorization, I will not be able to obtain assistance from the Merck PAP. I further understand that I may cancel the Authorization at any time by faxing a written notice of cancellation to: 1-800-528-2551. I understand that if I cancel the Authorization, that will not invalidate uses and disclosures of My Information made before the Merck 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.

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 and disclosures, Merck PAP intends to use and disclose my PHI only for the purposes described in this Authorization.
- I do not need to sign this Authorization in order to receive healthcare treatment or insurance benefits, but if I do not sign the Authorization, I will not be able to obtain assistance from the Merck PAP.
- I may cancel this Authorization at any time by mailing a written request to Merck Patient Assistance Program, PO Box 1206, Wilkes Barre, PA 18703-1206, or by calling 1-800-293-3881. I understand that canceling my Authorization will mean that my physicians, pharmacies, and health plans, as well as Merck PAP 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 Program will retain the information they have collected about me in accordance with Merck's records retention policy.
- 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.
- I understand that I am entitled to a copy of my signed Authorization and that I can obtain copies by mailing a written request to Merck Patient Assistance Program, PO Box 1206, Wilkes Barre, PA 18703-1206 or by calling 1-800-293-3881.

**SIGN
HERE**

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

Patient's Original Signature

Date (MM/DD/YYYY)

Legal Representative's Signature*

Date (MM/DD/YYYY)

If Signed by a Legal Representative, Please Describe
Your Authority to Act on Behalf of the Patient

Name of Signing Party (Please Print)

Phone Number of Legal Representative

DECLARATION OF 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.

*A Legal Representative is a person who has legal authority under applicable law to bind you (the Patient) by signing each Authorization or Declaration in this enrollment form.



SECTION 3: INCOME VERIFICATION

Provide current gross annual household income (your income before taxes), including Social Security and pension benefits:

Total Gross Annual
Household Income: _____

Number of Household Members (Including Patient)
Who Depend on This 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 any **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 Benefits Statement
- Income Verification Letter from an employer

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.

SIGN
HERE

Patients should only sign this section if they are selecting Option 2.

Patient's Original Signature

Date (MM/DD/YYYY)

Legal Representative's Signature*

Date (MM/DD/YYYY)

If Signed by a Legal Representative, Please Describe
Your Authority to Act on Behalf of the Patient

Applicant Declaration

I certify that all of the information provided by me in this application, including household income, is complete and accurate. I understand that Merck PAP is not responsible for checking or verifying any information contained in Section 4 of this application and that only the licensed Prescriber will be responsible for accuracy of the information contained in Section 4. I understand that assistance from the Merck PAP will terminate if the Merck PAP becomes aware of any fraud or if the vaccine covered by the Merck PAP is no longer indicated for me. I understand that completing this application does not ensure that I will qualify for the Merck 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 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 understand that the Merck PAP reserves the right to conduct periodic audits of the information I supplied on this enrollment form, and will require additional evidence from me to verify the information provided in this application. I understand that assistance received through the Merck PAP is not insurance.

SIGN
HERE

Patient's Original Signature

Date (MM/DD/YYYY)

Legal Representative's Signature*

Date (MM/DD/YYYY)

If Signed by a Legal Representative, Please Describe
Your Authority to Act on Behalf of the Patient

*A Legal Representative is a person who has legal authority under applicable law to bind you (the Patient) by signing each Authorization or Declaration in this enrollment form.

SECTION 4: LICENSED PRESCRIBER INFORMATION

Prescriber's First Name

M.I.

Prescriber's Last Name

Practice/Clinic Name

Address Line 1 (PO Boxes Not Permitted)

Address Line 2 (Suite/Building/Floor)

City

State

Zip

*Note: The address you provide above is where PAP 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)*

Fax

Office Phone Number

Ext.

Email

Office Contact Name

Facility Delivery Hours (Day/Times)

SECTION 5: 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

Is the Patient
in the Office?☐

Yes

☐

No

Have You Already
Administered This Dose?☐

Yes

☐

No

Merck PAP will replace the doses of vaccine administered to approved Patients via monthly shipments to the address you provided above. [Notes: Merck PAP 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.]

Confirmation number will be provided after the application is approved by the Merck Vaccine Patient Assistance Program.

Confirmation Number

Date of Administration

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 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 PAP or 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 PAP reserves the right to conduct periodic audits of the records of all entities receiving replacement of inventory in connection with Merck PAP. I accept that reasonable notice will be granted and audits will be conducted during regular business hours. I understand Merck PAP may suspend facility from utilization of the Program to new enrollees, at Merck PAP's discretion, without advance notice, if the facility does not commit to an audit (scheduling and completion). 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
HERE*(We cannot accept signature stamps.)*

Prescriber's Signature

Date (MM/DD/YYYY)

