The Merck Access Program
ENROLLMENT FORM

KEYTRUDA® (pembrolizumab) Injection 100 mg | KEYTRUDA Qlex™ pembrolizumab + berahyaluronidase alfa-pmph Subcutaneous Injection | 165 mg + 2,000 units/mL

Phone: 855-257-3932, Fax: 855-755-0518 or 480-663-4059 • The Merck Access Program, PO Box 2349, Columbus, OH 43216

TO ENROLL IN THE MERCK ACCESS PROGRAM, 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, PLEASE INCLUDE A PRESCRIPTION FOR THE PRODUCT SELECTED.

PLEASE CHECK ALL BOXES THAT APPLY AND COMPLETE THE APPROPRIATE SECTION(S) OF THE FORM

Product (select **one**): ☐ KEYTRUDA ☐ KEYTRUDA QLEX

To avoid delays in processing, please select one product only

☐ Patient Benefits Investigation and/or information about the Prior Authorization (PA) or Appeals Process

☐ Merck Co-pay Assistance Program

☐ Referral to the Merck Patient Assistance Program for an eligibility determination (provided through the Merck Patient Assistance Program, Inc.*)

*Merck Patient Assistance Program, Inc. is a 501c3 Foundation and is separate and distinct from The Merck Access Program and the Merck Co-pay Assistance Program.

PATIENT INFORMATION SECTION

Please note: Upon receipt of this Enrollment Form, an additional worksheet may be sent to the healthcare professional contact on page 7 for completion.

PATIENT INFORMATION

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

Patient name: _____ Date of birth: _____

Address: _____ City: _____ State: _____ ZIP: _____
(Street address only, no PO boxes)

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

INSURANCE INFORMATION

PLEASE COMPLETE ALL THAT APPLY AND **INCLUDE A FRONT AND BACK COPY OF INSURANCE CARD** FOR EACH TYPE OF INSURANCE

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

Please include a copy of the PA Approval (if available). **Prior Authorization 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	PRESCRIPTION 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.			

PATIENT INFORMATION SECTION

PROGRAM ENROLLMENT & 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, the Merck Patient Assistance Program, the My Merck Support 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-keytruda.com/keytrudaqlex/hcc/enrollment.html. 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.

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, the Merck Patient Assistance Program, the My Merck Support 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, My Merck Support 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.

(*continued on next page*)

PATIENT INFORMATION SECTION

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION (*continued*)

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-keytruda.com/keytrudaqlex/hcc/enrollment.html. 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: _____

Patient name: _____ Date of birth: _____

PATIENT INFORMATION SECTION

THE MERCK CO-PAY ASSISTANCE PROGRAM TERMS AND CONDITIONS

The Merck Co-pay Assistance Program for KEYTRUDA® (pembrolizumab) Injection 100 mg or KEYTRUDA QLEX™ (pembrolizumab and berahyaluronidase alfa-pmph) Injection 165 mg + 2,000 units/mL (each individually, a "Program Product").

To receive benefits under the Co-pay Assistance Program, the patient must enroll in the Co-pay Assistance Program and be accepted as eligible. A patient's eligibility for the Co-pay Assistance Program will commence upon the date of The Merck Access Program's acceptance of patient's enrollment and will continue for twelve months thereafter ("Eligibility Period"), so long as the patient satisfies all eligibility criteria of the Co-pay Assistance Program for each date of administration of the Program Product.

- Patient must be prescribed the Program Product for an FDA-approved indication.
- Patient must have private health insurance that provides coverage for the cost of the Program Product under a medical benefit plan or a pharmacy benefit plan.
- **The Co-pay Assistance Program is not valid for patients covered under Medicaid (including Medicaid patients enrolled in a qualified health plan purchased through a health insurance exchange [marketplace] established by a state government or the federal government), Medicare, a Medicare Part D or Medicare Advantage plan (regardless of whether a specific prescription is covered), TRICARE, CHAMPUS, Puerto Rico Government Health Insurance Plan ("Healthcare Reform"), or any other state or federal medical or pharmaceutical benefit program or pharmaceutical assistance program (collectively, "Government Programs"). The Co-pay Assistance Program is not valid for uninsured patients.**
- Patient must be a resident of the United States or the Commonwealth of Puerto Rico. Product must originate and be administered to patient in the United States or the Commonwealth of Puerto Rico.
- **Subject to changes in state law, the Co-pay Assistance Program may become invalid for residents of Massachusetts prior to its expiration date.**
- All information applicable to the Co-pay Assistance Program requested on The Merck Access Program Enrollment Form must be provided, and all certifications must be signed. Forms that are modified or do not contain all the necessary information will not be eligible for benefits under the Co-pay Assistance Program.
- **Patient must pay the first $25 of co-pay per administration of Program Product.** The benefit available under the Co-pay Assistance Program is limited to the amount indicated on the documentation provided by the patient's private health insurance company, which can include, but is not limited to, an Explanation of Benefits (EOB) or a Remittance Advice (RA), that the patient is obligated to pay for the Program Product, less $25, up to the Co-pay Assistance Program per patient maximum. The maximum Co-pay Assistance Program benefit per patient per Eligibility Period is $25,000.
- Patient must have an out-of-pocket cost for the Program Product and be administered the Program Product during the patient's Eligibility Period or the 90-Day Lookback Period (defined below) **AND** during the Term (defined below) of the Co-pay Assistance Program. The benefit available under the Co-pay Assistance Program is valid for the patient's out-of-pocket cost for the Program Product only. It is not valid for any other out-of-pocket costs (for example, office visit charges or medication administration charges) even if such costs are associated with the administration of the Program Product. The claim for Program Product must be submitted by the patient's healthcare provider or pharmacy (both referred to as "Provider") to patient's private health insurance separately from other services and products.
- To receive the benefit available under the Co-pay Assistance Program, patient or Provider must submit documentation provided by the patient's private health insurance company that contains the following information: name of the patient's private health insurance company, patient's insurance plan details (patient ID, policy/group/payor ID, and, for pharmacy benefit claims only, BIN and PCN); patient's demographic information (full name, date of birth, and address); patient's out-of-pocket cost for Program Product; confirmation that the Program Product was administered to the patient; date of Program Product administration to the patient; and submission of the claim by the Provider for the cost of the Program Product. The documentation must also show that the Program Product was paid separately from other services and products.
- The documentation provided by the patient's private health insurance company, which can include, but is not limited to, an EOB or RA, must be submitted to the Co-pay Assistance Program within **180 days** of the date the claim was processed for patient to receive a co-pay assistance benefit; provided, however, that no claims may be submitted more than **180 days** after the expiration date of the Co-pay Assistance Program.
- The Co-pay Assistance Program may apply to patient out-of-pocket costs incurred for a Program Product that was administered **up to 90 days** prior to the start date of the patient's Eligibility Period ("90-Day Lookback Period"), subject to the Co-pay Assistance Program per patient maximum and the applicable Terms and Conditions based on Program Product administration date. Patient or Provider may contact The Merck Access Program for more information. The 90-Day Lookback Period does not apply to KEYTRUDA QLEX™ (pembrolizumab and berahyaluronidase alfa-pmph) prior to the initial FDA approval date.
- Patient and Provider agree not to seek reimbursement for all or any part of the benefit received by the patient through the Co-pay Assistance Program. Patient and Provider are responsible for reporting receipt of Co-pay Assistance Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Co-pay Assistance Program, as may be required.
- No other purchase is necessary.
- **The Co-pay Assistance Program is not insurance.**
- The Merck Access Program Enrollment Form may not be sold, purchased, traded, or counterfeited. Void if reproduced.
- The Co-pay Assistance Program is void where prohibited by law, taxed, or restricted. The Co-pay Assistance Program is not transferable. No substitutions are permitted.
- The Co-pay Assistance Program benefit cannot be combined with any other Co-pay Assistance Program, free trial, discount, prescription savings card, or other offer.
- If acquiring Program Product from a Specialty Pharmacy (to be later administered in a physician office or outpatient institution), additional documentation may be required.
- Merck reserves the right to rescind, revoke, or amend the Co-pay Assistance Program at any time without notice.
- De-identified and aggregate data related to your redemption of the coupon may be collected, analyzed, and shared with Merck, for market research and other purposes related to assessing coupon programs. This data will not identify you.
- The term of the Co-pay Assistance Program is from September 23, 2025, through September 30, 2027 ("Term"). A patient may have only one Eligibility Period during the Term of the Co-pay Assistance Program. Enrollment into the Co-pay Assistance Program will automatically terminate patient's eligibility in any other Merck Co-pay Assistance Program for Program Product.
- **Program Group Number: 2456, Expiration Date: 09/30/2027**

PATIENT CERTIFICATION: THE MERCK CO-PAY ASSISTANCE PROGRAM

I certify that I have read and understand the Terms and Conditions of the Merck Co-pay Assistance Program for KEYTRUDA® (pembrolizumab) Injection 100 mg or KEYTRUDA QLEX™ (pembrolizumab and berahyaluronidase alfa-pmph) Injection 165 mg + 2,000 units/mL (each individually, a "Program Product"). I certify that I meet the eligibility requirements listed in the Terms and Conditions and that the information I am providing on The Merck Access Program Enrollment Form is true and correct. I understand that my eligibility for the Co-pay Assistance Program will commence upon the date of The Merck Access Program's acceptance of my enrollment and will continue for twelve months thereafter ("Eligibility Period"), so long as I satisfy all eligibility criteria of the Co-pay Assistance Program for each date of administration of the Program Product. I understand that I may have only one Eligibility Period during the Term (defined below) of the Co-pay Assistance Program.

I certify that I have private insurance and that no part of the costs associated with the Program Product for which I am seeking a benefit under the Co-pay Assistance Program was or will be covered or reimbursed by a Government Program, as that term is defined in the Terms and Conditions of the Co-pay Assistance Program.

I understand that if I begin to have coverage under any Government Program or if my state prohibits the redemption of manufacturer Co-pay Assistance (coupons) at any time, I will no longer be eligible to receive benefits under the Co-pay Assistance Program. If I am enrolled in a qualified health plan purchased through a health insurance exchange established by a state government or the federal government (QHP), I understand that if the federal government or my state government prohibits the redemption of manufacturer Co-pay Assistance (coupons) by enrollees in QHPs at any time, I will no longer be eligible to receive benefits under the Co-pay Assistance Program.

I certify that my insurance company has not prohibited the redemption of manufacturer Co-pay Assistance (coupons) for the Program Product, and I understand that if at any time my insurance company prohibits the redemption of manufacturer Co-pay Assistance (coupons) for the Program Product, I will no longer be eligible to receive benefits under the Co-pay Assistance Program.

I understand that I am responsible for reporting receipt of Co-pay Assistance Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Co-pay Assistance Program, as may be required.

I agree not to seek reimbursement for all or any part of the benefit I receive through the Co-pay Assistance Program. I understand that my healthcare provider or pharmacy (both referred to as "Provider") will submit a claim to my private insurance company for the Program Product administered to me. I authorize my Provider to submit any necessary documentation provided by my private health insurance company, which can include, but is not limited to, an Explanation of Benefits (EOB) or a Remittance Advice (RA), to the Co-pay Assistance Program and to receive, on my behalf, if applicable, any benefit for which I am eligible under the Co-pay Assistance Program. I understand that my Provider will apply any amounts received from the Co-pay Assistance Program toward the satisfaction of my obligation for the cost of the Program Product only. I understand that I am responsible to pay my Provider the amount I owe per administration of Program Product consistent with the applicable Terms and Conditions of the Co-pay Assistance Program, and any balance owed to my Provider not covered by the Co-pay Assistance Program.

I understand that the Co-pay Assistance Program benefit is only available for my out-of-pocket costs incurred for a Program Product that was administered to me during my Eligibility Period or the 90-Day Lookback Period (as defined in the Terms and Conditions of the Co-pay Assistance Program) **AND** during the Term of the Co-pay Assistance Program.

I understand that any benefit I am eligible for under the Co-pay Assistance Program will be paid directly to my Provider, on my behalf, if applicable, or directly to me. If I have already paid my Provider for my share of the cost of the Program Product for which I later receive a benefit through the Co-pay Assistance Program, I will seek the amount, less the amount I owe per administration, if applicable in accordance with the Co-pay Assistance Program Terms and Conditions, back from my Provider.

If acquiring Program Product from a Specialty Pharmacy (to be later administered in a physician office or outpatient institution), I understand that additional documentation may be required.

I understand that I am free to switch Providers at any time without affecting my eligibility to receive benefits under the Co-pay Assistance Program; provided, however, that my new Provider must complete the information required on the form, including the Healthcare Provider and/or Specialty Pharmacist Certifications, as applicable, before any Co-pay Assistance Program benefit for which I am eligible may be paid, if applicable, to such Provider on my behalf.

I understand that the term of the Co-pay Assistance Program is from September 23, 2025, through September 30, 2027 ("Term").

I will inform the Co-pay Assistance Program immediately in the event my health insurance changes (for example, at the beginning of new calendar or benefit year).

Patient name: _____ Date of birth: _____

PATIENT INFORMATION SECTION

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 healthcare provider 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 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 PAP is not insurance.

MERCK PAP FINANCIAL HARDSHIP EXCEPTION

☐ **Patient requests consideration for Merck PAP Financial Hardship Exception**

If Patient does not meet the financial eligibility criteria for the Merck PAP Product, Patient may still request assistance if experiencing a financial hardship (ie, 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 are 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.

PATIENT ACKNOWLEDGMENT AND SIGNATURE

By signing, I certify that I have read and agree to the above Terms and Conditions and Patient Certification of the Merck Co-pay Assistance Program and the 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): _____

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
- Disability Statement
- Veteran Benefits Statement
- Unemployment Benefit Statement
- Social Security Benefits Letter
- One month of pay stubs, prior to the application date
- Pension Letter
- Letter from an employer

If selecting Option 1, include a COPY of only **ONE** of these documents with your completed 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): _____

Patient Information section continues on the next page.

PATIENT INFORMATION SECTION

OPTIONAL MOBILE AUTHORIZATION

I agree that The Merck Access Program, the Merck Patient Assistance Program, the My Merck Support Program (collectively, 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"), to the extent I voluntarily enroll in the Programs by Merck, may send me communications about resources and services related to my enrollment in the Programs via telephone call and text message. The number and type of calls and text messages will be based upon my program selections, and message and data rates may apply. At any time, I may request to stop telephone calls or text messages by following the opt-out directions provided during those communications. I UNDERSTAND THAT THESE COMMUNICATIONS MAY USE PRERECORDED/ARTIFICIAL VOICE MESSAGES AND/OR AN AUTOMATED SYSTEM AND THAT I DO NOT NEED TO AGREE TO RECEIVE CALLS/TEXT MESSAGES AS A CONDITION OF PURCHASING OR RECEIVING ANY PRODUCTS OR SERVICES FROM MERCK.

- I **CONSENT** to the terms above. Please list your mobile phone number: _____
- I **DO NOT CONSENT** to the terms above.

OPTIONAL ENROLLMENT IN THE MY MERCK SUPPORT PROGRAM

If you consent below, you are permitting Merck to collect, use, and disclose to vendors and third parties your information (1) so that you can join the My Merck Support Program; (2) to verify your eligibility to join the My Merck Support Program; (3) to communicate with you via US postal mail, telephone, and email about program materials and the My Merck Support Program; (4) to ensure compliance with laws, Merck policies, and rules of the My Merck Support Program; (5) to allow Merck to analyze the My Merck Support Program, including the customer support services provided, to evaluate, improve, and better provide the services, including through AI-assisted technologies; and (6) to send you educational resources about the My Merck Support Program, treatment information, and other materials created by the My Merck Support Program.

This Authorization is completely voluntary. However, if you do not sign the Authorization, Merck will not be able to have you join in the My Merck Support Program or provide the resources developed for that program. This Authorization will have no impact on your eligibility for treatments, payments, enrollments, or eligibilities for government or private insurance benefits.

You may withdraw this Authorization at any time by calling 1-888-776-8364 or by visiting mymercksupportteam.com. Unless you withdraw this Authorization sooner, it will be valid until (i) 5 years from execution; (ii) you request to be removed from the My Merck Support Program; or (iii) as otherwise specified by applicable law, whichever is shorter. If you revoke your Authorization by opting out, it will take effect as soon as your revocation notice is received but will not invalidate uses or disclosures of your information by Merck made in reliance on the Authorization prior to our receipt of your notice of revocation.

- ☐ I **CONSENT** to the collection of my health information per the terms above.
- ☐ I **CONSENT** to the sharing and disclosure of my health information as identified above.
- ☐ I **DO NOT CONSENT** to the terms above.

Please note: You must check both boxes starting with "I Consent" above to enroll in the *My Merck Support Program.*
Participation is voluntary, and if you do not wish to enroll, please check "I DO NOT CONSENT to the terms above."

Patient name: _____ Date of birth: _____

HEALTHCARE PROVIDER INFORMATION SECTION

HEALTHCARE PROVIDER INFORMATION (to be completed by healthcare provider)

Healthcare provider name: _____

Healthcare provider tax ID no.: _____

Healthcare provider NPI no.: _____

Address: _____
(Street address only, no PO boxes)

City/state/ZIP: _____

Phone: _____ Ext: _____

Fax: _____

Office contact person: _____

Office contact number: _____ Ext: _____

Email: _____

Please indicate benefit preference: Medical Pharmacy

Buy and Bill (medical) On-site pharmacy Specialty pharmacy

Pharmacy name: _____

Pharmacy address: _____

Practice/Facility name: _____

Practice tax ID no.: _____

Practice NPI no.: _____

Practice/Facility address: _____
(Street address only, no PO boxes)

City/state/ZIP: _____

Please list primary diagnosis code and description:

_____

_____

Please code to the highest level of specificity. Use of an unspecified code may delay the MAP Enrollment Process.

Please refer to the Prescribing Information for KEYTRUDA or KEYTRUDA QLEX for a full list of indications.

Monotherapy **In combination with:** _____

Next treatment date: _____

Pharmacy phone: _____

Pharmacy fax: _____

HEALTHCARE PROVIDER CERTIFICATION: THE MERCK CO-PAY ASSISTANCE PROGRAM

I, a licensed healthcare professional, certify that KEYTRUDA® (pembrolizumab) Injection 100 mg or KEYTRUDA QLEX™ (pembrolizumab and berahyaluronidase alfa-pmph) Injection 165 mg + 2,000 units/mL (each individually, a "Program Product") has been prescribed to the patient indicated on The Merck Access Program Enrollment Form in the exercise of the prescriber's independent medical judgment for an FDA-approved indication.

I have read and agree to the Terms and Conditions of the Merck Co-pay Assistance Program. I certify that, to the best of my knowledge, the patient meets the criteria set forth in the Terms and Conditions, and that the information I am providing is true and correct.

I certify that I/my facility will not take into account the fact that the patient may receive a benefit from the Co-pay Assistance Program when determining the amount of any charge(s) to the patient.

I certify that I/my facility will not charge the patient any fee to complete The Merck Access Program Enrollment Form and I/my facility will not advertise or otherwise use the Co-pay Assistance Program as means of promoting my services or the Program Product.

I certify that the claim I submit/my facility submits to the patient's private health insurer for payment of the Program Product will have the Program Product listed separately from any claim for medication administration or any other items or services provided to the patient.

I understand that I am/my facility is responsible for reporting receipt of Co-pay Assistance Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Co-pay Assistance Program, as may be required.

I certify that I/my facility will not seek reimbursement for all, or any part of, the benefit received by the patient through the Co-pay Assistance Program.

I understand that the patient's benefit received under the Co-pay Assistance Program will be paid directly to me/my facility by the Co-pay Assistance Program on behalf of my patient. I/my facility will apply any amounts received from the Co-pay Assistance Program to the satisfaction of the patient's obligation for the cost of the Program Product only. If I/my facility already received payment from the patient for the patient's share of the cost of the Program Product for which the patient receives a benefit through the Co-pay Assistance Program, I/my facility will refund the amounts received (minus the patient's obligation per administration in accordance with the Co-pay Assistance Program Terms and Conditions) back to the patient.

I understand and agree that the certifications I am providing in this Healthcare Provider Certification apply to the patient indicated on The Merck Access Program Enrollment Form and to any other patient enrolled in the Co-pay Assistance Program whom I treat with the Program Product and any claim I submit/my facility submits for Co-pay Assistance Program benefits on the patient's behalf.

I understand that I may be asked to sign a new Healthcare Provider Certification if the Terms and Conditions of the Co-pay Assistance Program for the Program Product change.

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 ("Merck PAP") (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 KEYTRUDA and/or KEYTRUDA QLEX, that I have determined that KEYTRUDA or KEYTRUDA QLEX 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 KEYTRUDA or KEYTRUDA QLEX through the Merck PAP, neither I nor my Practice will receive any reimbursement from Merck, whether for administration fees or otherwise, from any source. I understand that Merck PAP reserves the right to modify or discontinue the Merck Patient Assistance Program at any time and without notice. I certify that I will not seek reimbursement or credit for any Merck PAP donated product from any insurer, health plan, or government program. 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.

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 or 480-663-4059