MerckHelps™

Merck Vaccine Patient Assistance Program

Phone: 1-800-293-3881 | **Fax:** 1-800-528-2551

PROGRAM INFORMATION

As part of its commitment to patients and providers, the Merck Vaccine Patient Assistance Program, Inc. (PAP) makes certain Merck adult vaccines available to eligible patients who lack third-party coverage and cannot afford to pay for their vaccines.

To be eligible for PAP, both the prescribing health care professional AND the patient must complete and sign this program application form and certify that:

1. A health care professional determined that the patient should be vaccinated with a Merck vaccine available through this program.

2. The patient currently lives in the United States and is aged 19 or older (the patient does not need to be a US citizen).

3. The patient does not have health insurance or other coverage for vaccines. Examples of health insurance include:

a. Private insurance
b. Health Maintenance Organizations (HMOs)
c. Medicaid or Medicare Part D
d. Veterans assistance, or any other social service agency support

AND

4. The patient cannot afford to pay for the vaccination and PAP can verify the patient meets the program's financial eligibility criteria. Information about specific financial criteria levels is available by 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 Assistance Program at 1-800-293-3881. Specialists are available to assist you Monday through Friday, 8 AM to 8 PM ET.

PROGRAM INSTRUCTIONS

1. Both the patient and a licensed health care professional must complete and sign the attached enrollment form.

2. The attached enrollment form must be completed, submitted, 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.

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The patient must authorize PAP to verify their current gross annual household income (household income before taxes are withdrawn) by either:

a. 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. By faxing the completed application form with 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
– One month of pay stubs, prior to application date
– Social Security Benefits Letter
– Veteran Benefits Statement
– Unemployment Benefit Statement
– Disability Statement
– Pension Letter
– Letter from an employer

The patient must include a copy of one of these documents with their completed, signed, and faxed enrollment form.

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 complete, and the patient's income authorization or supporting income documentation. Health care 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 above may have to return to the health care 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 above.

Scan to learn more about Merck's Patient Assistance Programs at MerckHelps.

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

MERCK VACCINE PATIENT ASSISTANCE PROGRAM APPLICATION

IMPORTANT: A DOSE OF MERCK VACCINE MUST NOT BE ADMINISTERED UNTIL AFTER THE MERCK VACCINE PATIENT ASSISTANCE PROGRAM (PAP) PROVIDES A CONFIRMATION NUMBER. This includes subsequent doses in a multidose series because a new application for each dose is required. Doses of vaccine administered before application submission and/or receipt of a confirmation number will not be replaced.

SECTION 1: APPLICANT INFORMATION *(Patient must complete all information in Section 1.)*

Patient's First Name | US Resident* [X] Yes [ ] No

Last Name

*You do not need to be a US citizen.

Address | Apt. No.

City | State | Zip

Phone | Date of Birth (M M D D Y Y Y Y) | Gender [ ] Male [ ] Female [ ] Other Identity

Do you have Medicare insurance? . . . . . Yes ❑ No ☒

Medicare beneficiaries only: Do you have Medicare Part D? . . . . . Yes ❑ No ☒

Do you have any other health insurance coverage of any kind *(public or private)*? . . . . . Yes ❑ No ❑

Examples: *Medicaid, Veterans benefits, health maintenance organization (HMO), preferred provider organization (PPO), college health plan, federal or state insurance, or health assistance program*

Are you covered under another individual's health insurance plan? . . . . . Yes ❑ No ❑

Are you claimed as a dependent on another individual's tax return? . . . . . Yes ❑ No ❑

Current gross annual household income (income before taxes): $_____

Number of people living in this household who are dependent on the household's income (including applicant): _____

Please read the Income Verification and Applicant Declarations, and sign each section to indicate your agreement.

APPLICANT DECLARATIONS

I certify that all of the information provided by me in this application, including household income, is complete and accurate. I understand that PAP is not responsible for checking or verifying any information contained in Section 2 of this application and that only the licensed prescriber will be responsible for accuracy of the information contained in Section 2. I understand that assistance from the PAP will terminate if the PAP becomes aware of any fraud or if the vaccine covered by the PAP is no longer indicated for me. I understand that completing this application does not ensure that I will qualify for the 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 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 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 PAP is not insurance.

SIGN **Patient's Original Signature:**_____ **Date:**_____

Patient name (first, last) _____

INCOME VERIFICATION

I understand the Merck Vaccine Patient Assistance Program, Inc. (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 PAP and other individuals involved in administering the PAP to obtain my consumer report and/or other information related to my credit report to determine my eligibility to participate in the program. I understand this verification will not affect my credit rating.

Sign Here: _____ **Date:** _____

NOTE: As an alternative to the above authorization, you may send any ONE of the documents listed on the cover page of this application form to verify the household income you provided on this form.

You must include a copy of this document with your completed and signed application form. Fax the completed and signed application with any one of the supporting documents listed on the cover page to: 1-800-528-2551.

❑ Check here if you are faxing a document to verify your current gross annual household income

Please read the *Applicant Authorization* and sign the section to indicate your agreement.

APPLICANT AUTHORIZATION

By signing below, I authorize my health care provider(s) and health plans, including Medicare, to disclose to the PAP and other individuals involved in administering the PAP my personal health information, including the information provided by my health care provider on the PAP Application form and other information related to my participation in the PAP (collectively, "My Information"), so that the PAP may use the information to (i) assess my qualification for the PAP, (ii) provide me with PAP assistance, (iii) administer the PAP, and (iv) monitor, audit, access, and evaluate the PAP's implementation and effectiveness. I authorize the PAP to use and disclose My Information for the foregoing purposes, including to make disclosures to PAP affiliates and contractors and to my health plans, including Medicare, and to contact me as part of 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 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 health care treatment or insurance benefits, but that if I do not sign the Authorization, I will not be able to obtain assistance from the 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 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.

Patient Signature

SIGN

_____	_____	_____
Name of Patient	Signature	Date
_____	_____	_____
Name of Legal Representative	Signature	Date

If signed by Legal Representative, describe the nature of relationship with patient (eg, does this person have Power of Attorney, act as a health care proxy, or have recognized legal authority to make health decisions on behalf of the patient):

_____

NOTE to Health Care Provider: You and your patient must complete and sign all sections of this application before faxing for eligibility review.

Patient name (first, last) _____

SECTION 2: LICENSED PRESCRIBER INFORMATION *(Health care provider must complete and sign Sections 2 and 3.)*

First, Last Name

Practice/Clinic Name: UMKC STUDENT HEALTH & WELLNESS

Address: 5110 OAK STREET Ste/Flr: 237

City: KANSAS CITY State: MO Zip: 64112

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) Date of Expiration: _____

Office Contact Person: RENEE

Phone Number: 816-235-6133 Fax Number: 816-235-6565

Facility Delivery Hours (day/times): 8:30 AM. TO 5:00 PM.

SECTION 3: VACCINE INFORMATION

Merck Vaccine Product Name: GARDASIL 9 NDC Number: #_____

Please indicate the enrolling patient's Dose Number for this Merck Vaccine: ❑ Dose #**1** ❑ Dose #**2** ❑ Dose #**3**

Have you already administered this dose? Yes ❑ No ☒

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

To be completed after application is approved by a Merck Vaccine Patient Assistance Program Representative

Confirmation Number: #_____

Date of Administration: _____/_____/_____ **Merck Vaccine Lot Number: #**_____

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 Vaccine 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 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 PAP reserves the right to conduct periodic audits of the records of all entities receiving replacement of inventory in connection with PAP. I accept that reasonable notice will be granted and audits will be conducted during regular business hours. I understand PAP may suspend facility from utilization of the Program to new enrollees, at 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 **Licensed Prescriber's Original Signature:** _____ **Date:** _____

(No stamps accepted)

FAX COMPLETED APPLICATION TO 800-528-2551