# The Merck Access Program
# HEALTHCARE PROVIDER ENROLLMENT FORM

KEYTRUDA® (pembrolizumab) Injection 100 mg

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

**TO GET STARTED, COMPLETE THE HEALTHCARE PROVIDER ENROLLMENT FORM. IF THE PATIENT IS REQUESTING A REFERRAL TO THE MERCK PATIENT ASSISTANCE PROGRAM, PLEASE INCLUDE A PRESCRIPTION FOR KEYTRUDA.**

**PLEASE ENSURE THE PATIENT COMPLETES AND SUBMITS THE PATIENT ENROLLMENT FORM FOUND AT WWW.MERCKACCESSPROGRAM-KEYTRUDA.COM/HCC.**

**PLEASE CHECK ALL BOXES THAT APPLY AND COMPLETE THE CORRESPONDING SECTION(S) REFLECTING THE SUPPORT REQUESTED BY YOUR PATIENT.**

**If you do not know what support the patient is requesting, please consult the patient.**

- ☐ Patient Benefit 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.

Please note: Upon receipt of this Enrollment Form, an additional worksheet may be sent to the healthcare professional contact on page 2 for completion.

Patient name:_____ Date of birth:_____

Patient address:_____
(Street address/city/state/zip)

## PATIENT INSURANCE INFORMATION

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

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

**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. | | | |

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

Healthcare provider name: _____

Healthcare provider tax ID no.: _____

Healthcare provider NPI no.: _____

Healthcare provider State license no.: _____ Expiration date: _____

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

City/state/zip: _____

Phone: _____ Fax: _____

Office contact person: _____

Office contact number: _____

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.

**Product use is consistent with labeled indications for KEYTRUDA: Yes ❑ No ❑**

**Please refer to the Prescribing Information for KEYTRUDA for a full list of indications**

❑ **Monotherapy** ❑ **In combination with:** _____

**Next treatment date:** _____

Pharmacy phone: _____

Pharmacy fax: _____

## THE MERCK CO-PAY ASSISTANCE PROGRAM TERMS AND CONDITIONS

**The Merck Co-pay Assistance Program for KEYTRUDA® (pembrolizumab) Injection 100 mg ("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. A patient may contact The Merck Access Program to inquire about the current Program Product(s) that are subject to these Terms and Conditions.

- 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 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.
- 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.
- Data related to patient's receipt of Co-pay Assistance Program benefits may be collected, analyzed, and shared with Merck, for market research and other purposes related to assessing Co-pay Assistance Programs. Data shared with Merck will be aggregated and de-identified, meaning it will be combined with data related to other Co-pay Assistance Program redemptions and will not identify patient.
- The term of the Co-pay Assistance Program is from August 1, 2023, through October 30, 2025 ("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: 2395, Expiration Date: 10/30/2025**

## HEALTHCARE PROVIDER CERTIFICATION: THE MERCK CO-PAY ASSISTANCE PROGRAM

I, a licensed healthcare professional, certify that KEYTRUDA® (pembrolizumab) Injection 100 mg ("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 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

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 KEYTRUDA.
- 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 the 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 the administrator of Merck's field access and reimbursement support team, including its contractors, representatives, or third-party services partners (collectively, "Field Access and Reimbursement Support Administrator"), and authorizes the Programs and Field Access and Reimbursement Support Administrator (together with their respective administrators, contractors or other affiliates) to use and disclose the PHI for purposes of benefits investigation and reimbursement support.
- I represent and warrant that if my Practice uses a Third-Party Administrator (TPA), the TPA is authorized to act on my behalf to submit enrollment forms to Merck PAP and that the TPA has been trained on Merck PAP rules and requirements before providing services related to Merck PAP.
- I understand that a TPA may not sign on behalf of the patient.
- 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.
- I certify that the Program Product is being used in an outpatient setting only.
- 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.
- 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.
- Neither I nor my Practice will receive any reimbursement from Merck, whether for administration 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 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 Program by telephone, email, and/or fax.
- The information provided is complete and accurate to the best of my knowledge.

Does the Facility use a Third-Party Administrator (TPA) to administer and manage its patient assistance programs? Yes ☐ No ☐

**By signing, I certify that I have read and agree to the above Healthcare Provider Certification and Attestation (if applicable based on the support my patient requested).**

**By signing, I also certify that all information that I have provided in this enrollment form is complete and accurate.**

**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.**

MERCK