The Merck Access Program

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 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 KEYTRUDA.

Check off the relevant box(es).

Please be sure to send a prescription for KEYTRUDA.

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

- ☐ 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 6 for completion.

PATIENT INFORMATION SECTION

PATIENT INFORMATION

Fill out patient information completely.

Patient is a US resident Yes ☐ No ☐

Check off the box applicable to the patient.

Patient name: ________ Date of birth: ________

Address: ________ City/state/zip: ________

(Street address only, no PO boxes)

Phone (home): ________ (work): ________ (cell/mobile): ________

Email: ________

INSURANCE INFORMATION

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

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

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

Include Prior Authorization number 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**

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

	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.			

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

Write the patient's name on each page of the enrollment form.

Patient name: ______________________________

PATIENT INFORMATION SECTION

PATIENT AUTHORIZATION

I understand that, before I may have communications with The Merck Access Program, sponsored by Merck Sharp & Dohme LLC ("Merck"), a subsidiary of Merck & Co., Inc., or receive assistance from the Merck Patient Assistance Program ("Merck PAP"), sponsored by the Merck Patient Assistance Program, Inc. (individually, "a Program"; collectively, "the Programs"), the administrators of the Programs, including their contractors or other representatives, will need to obtain, review, use, and disclose my personal health information ("PHI"), including information relating to my medical condition and prescription medications and the information included in this patient enrollment form.

I therefore authorize each of my physicians, pharmacies, and health plans to disclose my PHI, as necessary, to (i) Merck and the Programs; (ii) the administrators of the Programs, their contractors, third-party service providers, and representatives (collectively, "Program Administrators"); and (iii) the administrator of Merck's field access and reimbursement support team, its contractors, representatives, and third-party services partners (collectively, the "Field Access and Reimbursement Support Administrator") in order to (i) verify my eligibility to enroll in the Programs; (ii) enroll me in the Programs for which I am eligible; (iii) provide reimbursement support; and (iv) investigate insurance coverage in connection with The Merck Access Program.

I also authorize Merck, the Programs, the Program Administrators, and Field Access and Reimbursement Support Administrator, and their respective contractors to use, share, and disclose my PHI for the following purposes: (i) to provide the services described in this enrollment form; (ii) to communicate with me by U.S. postal mail, telephone, text, or email; (iii) to prepare summaries that do not include my PHI for statistical purposes; (iv) to conduct analyses to help Merck evaluate, improve, and/or provide its services, customer support, and educational and/or promotional materials for patients prescribed Merck medications; and (v) to share my PHI with one another and with my physicians and pharmacists as well as with Medicare, my health plans, and their administrators, contractors, or representatives, in order for them to coordinate my benefits, provide, when applicable, reimbursement support, and investigate my insurance coverage.

I also authorize the Program Administrators and Field Access and Reimbursement Support Administrator to disclose my PHI to authorized representatives of Merck and the Programs as necessary to ensure compliance with the rules of the Programs. I also authorize Merck's authorized representatives to use my PHI to communicate with the Program Administrators, Field Access and Reimbursement Support Administrator, my physicians, pharmacies, and me for compliance purposes.

If I have designated a Legal Representative, I authorize Merck, the Programs, Program Administrators, and Field Access and Reimbursement Support Administrator to use my PHI to contact the person I have designated as my Legal Representative for the purpose of verifying the information I have provided in this form and/or coordinating the provision of benefits that may be available to me under the Programs, and to disclose my PHI to my Legal Representative for the purposes described in this authorization.

I understand that the PHI disclosed pursuant to this authorization, once disclosed, may not be governed by the same privacy laws and may be subject to re-disclosure, but I also understand that the administrators of the Programs and their contractors and other representatives intend to use and disclose my PHI only for the purposes described in this authorization. I further understand that if I choose not to provide this authorization, it will not affect my eligibility for, or receipt of, treatment, including Merck products, or health care insurance benefits, but that I will not be able to receive any assistance from the Programs for which I may be eligible.

I understand that I may cancel this authorization at any time by telephoning The Merck Access Program at (855) 257-3932 or by mailing a written request for cancellation to The Merck Access Program, PO Box 2349, Columbus, OH 43216. I understand that canceling my authorization will mean that my physicians, pharmacies, and health plans, as well as the Field Access and Reimbursement Support Administrator, Merck, the Programs, and the Program Administrators may no longer rely on the authorization to use or disclose my PHI, but that any use or disclosure of such information that occurs before my cancellation is received will be unaffected by my cancellation.

Write the patient's name on each page of the enrollment form.

Patient name: ____________________

PATIENT INFORMATION SECTION

PATIENT AUTHORIZATION *(continued)*

I understand that if I do not cancel this authorization, the authorization will expire 15 months from the date of signature (or the maximum period allowed by applicable state law, if less than 15 months). The administrators of the Programs will retain the information I have submitted in accordance with Merck's records retention policy.

I understand that I am entitled to receive a copy of this authorization once it has been signed and may request a copy by contacting The Merck Access Program at the contact information provided above.

By signing, I certify that I have read and agree to the above Patient Authorization based on the support I have requested.

The patient or legal representative should sign here.

Date is required.

PATIENT SIGNATURE

Signature of patient, parent, legal guardian, 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: ____________________

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**

Write the patient's name on each page of the enrollment form.

Patient name: ______________________________

PATIENT INFORMATION SECTION

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 ("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 August 1, 2023, through October 30, 2025 ("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).

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 doctor or prescriber licensed in the US.
- Patient does not have insurance or other coverage for the Program Product.
- Patient meets certain financial eligibility criteria.

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

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.)

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.
- 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.

Write the patient's name on each page of the enrollment form.

Patient name: ______

PATIENT INFORMATION SECTION

MERCK PAP FINANCIAL HARDSHIP EXCEPTION

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

If Patient does not meet the prescription drug coverage criteria, Patient may still request assistance if experiencing a financial hardship (i.e., 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, parent, legal guardian, or legal representative: ______ **Date:** ______

Name of signing party (please print): ______

Relationship to patient (if other than patient signing): ______

The patient or legal representative should sign here.

Date is required.

MERCK PAP INCOME VERIFICATION

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

a. OPTION 1: 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. OPTION 2: 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 2, include a COPY of only **ONE** of these documents with your completed, signed, and dated enrollment form. Please do not send an original document.

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 SIGNATURE

Signature of patient, parent, legal guardian, or legal representative: ______ **Date:** ______

Name of signing party (please print): ______

Relationship to patient (if other than patient signing): ______

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: ______ 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: ______

Include the email address of the office contact person.

The healthcare provider must indicate benefit preference.

The healthcare provider must indicate how they are obtaining the product.

Include the primary diagnosis code and description.

Refer to the Prescribing Information and indicate the treatment type.

Include the patient's next treatment date.

Write the patient's name on each page of the enrollment form.

Patient name: ______________________________

HEALTHCARE PROVIDER INFORMATION SECTION

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 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

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 ☐

The healthcare provider must indicate if their facility uses a Third-Party Administrator.

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.

The healthcare provider must sign here.

Date is required.

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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