

The ACT Program

PATIENT ENROLLMENT FORM

Fax completed form to
the ACT Program:
866-363-6389
For inquiries please call
866-363-6379

Please use this form to request reimbursement support and/or to have the patient referred to the patient assistance program.
Support Requested (check all that apply) Patient Benefit Investigation
 Referral to Patient Assistance Program

PATIENT INFORMATION

Patient name: _____ Date of birth (DOB): _____

MM/DD/YYYY

Address: _____ Male Female

(Please provide a street address only, no PO boxes.)

City/State/Zip: _____

Phone (home): _____ (work): _____ (other): _____

Only required for Patient Assistance Program

Current annual household income: \$ _____ Number of household members (including patient): _____

Indicate source(s) of your income by checking all boxes that apply:

Social Security benefits (SS, SSI, SSDI) Wages Pension Interest/dividends Unemployment compensation

List other income sources: _____

INSURANCE INFORMATION

PLEASE COMPLETE ALL THAT APPLY AND INCLUDE COPY OF CARD FOR EACH TYPE OF INSURANCE

Primary insurer (including Medicaid, Medicare, Veteran's Benefits, and private insurers)

Plan name and state: _____ Phone number for customer service: _____

Name of policyholder: _____ Policyholder date of birth: _____

Policy ID No.: _____ Group No.: _____

Secondary/Supplemental insurer

Plan name and state: _____ Phone number for customer service: _____

Name of policyholder: _____ Policyholder date of birth: _____

Policy ID No.: _____ Group No.: _____

Prescription/Medicare Part D insurer

Plan name and state: _____ Phone number for customer service: _____

Name of policyholder: _____ Policyholder date of birth: _____

Policy ID No.: _____ Group No.: _____

Other insurer

Plan name and state: _____ Phone number for customer service: _____

Name of policyholder: _____ Policyholder date of birth: _____

Policy ID No.: _____ Group No.: _____

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Patient name: _____

HEALTH CARE PROVIDER TO COMPLETE

PLEASE INCLUDE COPY OF CURRENT PRESCRIPTION(S) IF REQUESTING PATIENT ASSISTANCE

Indicate Merck medicine(s):

- EMEND® (aprepitant) EMEND® (fosaprepitant dimeglumine) for Injection INTRON® A (interferon alfa-2b, recombinant) for Injection
 NOXAFIL® (posaconazole) Oral Suspension PEGINTRON® (peginterferon alfa-2b) Powder for Injection
 SYLATRON™ (peginterferon alfa-2b) for Injection TEMODAR® (temozolomide) TICE® BCG (BCG live for intravesical use)
 VICTRELIS™ (boceprevir) ZOLINZA® (vorinostat)

Next therapy date: _____ Chemotherapy cycle no.: _____ Frequency: _____

Regimen information: **EMEND® (aprepitant) only**

Chemotherapy regimen: _____

Concomitant medications: _____

Physician practice name: _____

Physician name: _____

Tax ID No.: _____ NPI No.: _____ Medicare No.: _____

Address: _____
(Please provide a street address only, no PO boxes.)

City/State/Zip: _____

Phone: _____ Fax: _____

Office contact person: _____ Office contact number: _____

HEALTH CARE PROVIDER SIGNATURE AND DECLARATION

MUST CONTAIN ORIGINAL SIGNATURE

I certify that the prescribed product is medically appropriate for the patient identified above and that I will be supervising the patient's treatment. I verify that the information provided is complete and accurate to the best of my knowledge. I understand that the patient must qualify financially and meet certain medical and financial criteria to be eligible for the patient assistance program. If the patient receives product through the patient assistance program, reimbursement for such product administered to the patient will not be sought from any source. I also understand that I will not receive any reimbursement from Merck, whether for administration fees or otherwise.

Physician's original signature: _____ Date: _____

Physician's name (please print): _____ License No.: _____

Before prescribing INTRON A, please read the Prescribing Information, including the Boxed Warning about fatal or life-threatening neuropsychiatric, autoimmune, ischemic, and infectious disorders.

Before prescribing PEGINTRON, please read the Prescribing Information, including the Boxed Warning about fatal or life-threatening neuropsychiatric, autoimmune, ischemic, and infectious disorders and ribavirin-associated birth defects and fetal deaths.

Before prescribing SYLATRON, please read the Prescribing Information, including the Boxed Warning about depression and other neuropsychiatric disorders.

Before prescribing TICE BCG, please read the Prescribing Information, including the Boxed Warning about potential risk for transmission of the live attenuated mycobacteria contained in TICE BCG.



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PO Box 18979
Louisville, KY 40261-0979

Patient name: _____

Applicant Authorization for Use and Disclosure of Personal Health Information

I understand that in order for The ACT Program, created by Merck Sharp & Dohme Corp. (Merck), a subsidiary of Merck & Co., Inc., and the Merck Patient Assistance Program, Inc. (Merck PAP) to provide me with assistance, they will need to obtain, review, use and disclose my personal health information (PHI), including information relating to my medical condition and information on my application form, and any prescription. I authorize my physician, pharmacy and my health plan(s) to disclose my PHI to The ACT Program and Merck PAP and their administrators as necessary to complete the application process or to verify my application. I further authorize The ACT Program, Merck PAP, and their administrators to use my PHI to provide services through this program, and to disclose the information to Medicare, my health plan(s), and their contractors for the purpose of coordination of benefits, reimbursement support, and investigating insurance coverage. I agree to allow the administrators of the programs to contact me via mail, telephone, or e-mail to carry out these services and communications. I understand that my name, address, and any other personal identifying information provided in my application will be available to The ACT Program, Merck PAP, and their affiliates. I understand that my PHI disclosed under this application may no longer be protected by privacy laws and may be re-disclosed by The ACT Program and Merck PAP only for the purposes described here. I also understand that non-identifiable information concerning program participants may be summarized for statistical or other purposes and provided to Merck, The ACT Program or the Merck PAP, but my identity will not be determinable from this summary information.

I understand that if I don't provide this Authorization, I will not be able to obtain assistance from The ACT Program and/or Merck PAP. I understand that I may cancel this Authorization at any time by mailing a written request for such cancellation to my prescribing physician, pharmacy, health plans, The ACT Program and Merck PAP, and the cancellation will not apply to any information already used or disclosed pursuant to this Authorization.

If I do not cancel this Authorization, the Authorization will expire 15 months from the date signed below. The ACT program will retain the information I have submitted in accordance with Merck's record retention policy. I have read this document or have had it explained to me. I understand that I may request a copy of this Authorization once it has been signed.

Patient's original signature: _____ Date: ___/___/___

Signature of legal representative (if applicable): _____ Date: ___/___/___

Applicant Declarations and Authorizations

I certify that all of the information provided in this application, including information about household income, is complete and accurate. I understand that program assistance will terminate if the program becomes aware of any fraud or if this medication is no longer prescribed for me. I understand that completing this application does not ensure that I will qualify for patient assistance. I certify that I will not seek reimbursement or credit for this prescription 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 the prescription or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs. I understand that Merck PAP reserves the right to modify the application form, modify or discontinue this program, or terminate assistance at any time and without notice. I authorize Merck PAP and its affiliates to forward the prescription to a dispensing pharmacy on my 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 me. With respect to this application, I understand that only the dispensing pharmacy will be responsible for such information.

Patient's original signature: _____ Date: ___/___/___

