

Instructions:

1. Complete ALL information on the enrollment form.
You may fill in the fields online and print it.
OR
You may print out the form and fill it out by hand using a black ballpoint pen.
2. Take the completed enrollment form to your physician/prescriber. **Both the physician/prescriber and the patient MUST sign the enrollment form.**
3. Have your physician/prescriber write your prescription(s) in Section 3 of the enrollment form.
 - A single enrollment form may include prescriptions for either or both products covered in the SUPPORT™ program.
 - Each prescription may not exceed a 90-day supply at a time, with a maximum of **3 refills**.
 - Each enrollment form is valid for up to 12 months; after **12 months** a new enrollment form will be required. Under certain circumstances, enrollment may be limited to a calendar year.
 - A separate SUPPORT™ Program enrollment form is **REQUIRED** for **each** patient.
4. Mail **completed** enrollment forms to:

SUPPORT Program
PO Box 305
San Bruno, CA 94066-9901

Please Note:

- Incomplete or incorrectly completed enrollment forms will be returned.
- **Section 3 is your prescription. There is no need to write your prescription on a separate prescription form.**
- Patient's prescription will be sent to the patient's home address unless otherwise requested by the patient/prescriber in Section 3 of the enrollment form.
- For additional enrollment forms or assistance, please call 1-800-850-3430.

SUPPORT™ Program

PATIENT ENROLLMENT FORM

ISENTRESS®
(raltegravir) Tablets

Fax number: 1-866-410-1913
Phone number: 1-800-850-3430

CRIVAN®
(indinavir sulfate)

PATIENT INFORMATION – SECTION 1

Patient Name: _____ Date of Birth (DOB): _____
Month, Day, Year

Address: _____

City/State/Zip: _____ Male Female

Phone (Home): _____ (Work): _____ (Other): _____

Current annual household income (eg, wages, social security benefits, pension): \$ _____

Number of household members (including patient): _____

INSURANCE INFORMATION – SECTION 2

Primary Insurance Name: _____ Secondary Insurance Name: _____

Phone: _____ Phone: _____

Subscriber: _____ DOB: _____ Subscriber: _____ DOB: _____

Subscriber ID No.: _____ Subscriber ID No.: _____

Policy/Group No.: _____ Policy/Group No.: _____

Applicant Authorization for Use and Disclosure of Personal Health Information

I understand that in order for the SUPPORT™ 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, it 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. I authorize my physician, pharmacy, and health plan(s) to disclose my PHI to the SUPPORT™ Program and Merck PAP, and their administrators as necessary to complete the application process or to verify my application. I understand that my name, address, and any other personal identifying information provided in my application will be available to the SUPPORT™ Program, Merck PAP, and their affiliates. I further authorize Merck PAP and its 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 administrator of this program to contact me via mail, telephone, or e-mail to carry out these services and communications. I understand that my PHI disclosed under this application may no longer be protected by privacy laws and may be re-disclosed by the SUPPORT™ 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 SUPPORT™ 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 won't be able to obtain assistance from the SUPPORT™ 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 SUPPORT™ 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. 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: ___/___/___

SUPPORT™ Program

PATIENT ENROLLMENT FORM

Applicant Declarations and Authorizations

I certify that all of the information provided in this application, including 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 this 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 this 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 the information.

Patient's Original Signature: _____ Date: ___/___/___

PRESCRIPTION INFORMATION – SECTION 3

THIS IS THE PRESCRIPTION. PHYSICIAN SHOULD COMPLETE THE PRESCRIPTION AND PRODUCT INFORMATION BELOW. PLEASE PRINT. (PLEASE DO NOT SUBMIT A PRESCRIPTION SEPARATE FROM THIS APPLICATION.)

Patient's First Name M.I.

Last Name

Date of Birth
M M D D Y Y Y Y

Product Name: _____ Strength: _____ Quantity: _____ Directions: _____ Refill: ___ (1, 2, or 3) Times

Product Name: _____ Strength: _____ Quantity: _____ Directions: _____ Refill: ___ (1, 2, or 3) Times

State License Number: _____ Date: _____

Ship product to: Physician's Office Patient's Home

ALLERGIES: None Please specify: _____

CURRENT MEDICATION(S) BEING TAKEN BY THE PATIENT: _____

PHYSICIAN CERTIFICATION – SECTION 4

(Must contain prescriber's original signature—no stamps)

I certify that this prescription is medically appropriate for the patient identified in Section 3 above and that I will be supervising the patient's treatments. I verify that the information provided is complete and accurate to the best of my knowledge. I authorize the SUPPORT™ Program, its affiliated companies, or its subcontractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient.

Physician's Original Signature: _____ Date: _____

Physician's Name (Please print): _____ DEA number: _____

Address: _____

City/State/Zip: _____ Phone: _____

License No.: _____ UPIN: _____ Fax: _____

Physician Office Contact: _____

