



# SUPPORT™ PATIENT ENROLLMENT FORM

Fax number: 1-866-410-1913

Phone number: 1-800-850-3430

Mailing address: SUPPORT, PO Box 305, San Bruno, CA 94066



## PATIENT INFORMATION – SECTION 1, PAGE 1

Patient Name: \_\_\_\_\_ Date of Birth (DOB): \_\_\_\_\_

Month, Day, Year

Address: \_\_\_\_\_  Male  Female

City/State/ZIP: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Other): \_\_\_\_\_

If you were enrolled in either the Expanded Access Program or a clinical trial program, please provide the site name and your unique patient identification number \_\_\_\_\_

## 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

I verify that the information provided in this enrollment form is complete and accurate. I authorize the program to obtain and disclose information from my prescribing physician, insurance company, and other information as necessary in order to complete the enrollment process or verify the accuracy of any information provided in this enrollment form and in order to provide services through this program. I further authorize the program and its administrators to use and disclose my personal medical information relating to this prescription to Medicare, my plan, and their contractors for the purpose of coordinating benefits and verifying the statements made by my physician and me in connection with my enrollment in the program. I understand that my name, address, and any other personal identifying information provided in this enrollment form will be available solely to LASH Group, the administrator of this program, and that this information will not be disclosed to anyone else, except as necessary to administer the program or as required by law. Merck & Co., Inc., (Merck) is not acting as a dispensing pharmacy. Merck is not responsible for checking or verifying any information contained in Section 3, including, but not limited to, allergies, medical conditions, or other medications that the patient is taking. With respect to this enrollment form, I understand that only the dispensing pharmacy will be responsible for the information contained in Section 3 of this enrollment form. I also understand that unless I change my selection sooner, my permission will expire 15 months from the date signed below.

Patient's Original Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## ENROLLMENT FOR SUPPORT™ PATIENT ASSISTANCE PROGRAM

### Patient Enrollment Information

Current annual household net income (income after taxes): \$ \_\_\_\_\_

Number of household members dependent on above income (including applicant): \_\_\_\_\_

### Applicant Declaration for the SUPPORT™ Patient Assistance Program

If I request participation in the SUPPORT™ Patient Assistance Program, I verify that the information provided in this enrollment form is complete and accurate and that without enrollment in the program I would not be able to afford this medication. I further understand that the SUPPORT™ Patient Assistance Program may request documentation to verify financial or insurance information as considered necessary to provide services to me. I understand that program assistance will terminate if I do not cooperate with efforts to verify information in this enrollment form; if I do not comply with the activities needed to identify/verify potential sources of alternate insurance or financial coverage; if the program becomes aware of any fraud; or if this medication is no longer being prescribed for me. I understand that Merck & Co., Inc., reserves the right, at any time and without notice, to modify the enrollment form; modify or discontinue any or all programs; or terminate assistance. I understand that completing this enrollment form does not ensure that I will qualify for product patient assistance. I further certify that if my medication is provided under the SUPPORT™ Patient Assistance Program, I will not seek reimbursement or credit for this prescription from any insurer, health maintenance organization, or government program, and that 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 expenditure or out-of-pocket cost for prescription drugs.

Patient's Original Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



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Month, Day, Year

### 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

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

I certify that this prescription is medically indicated for the patient identified in Section 1 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.

Physician's Original Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name (Please print): \_\_\_\_\_ DEA number: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_ Phone: \_\_\_\_\_

License No.: \_\_\_\_\_ UPIN: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician Office Contact: \_\_\_\_\_

