



### APPLICATION

**MERCK HOTLINE FOR INVANZ® (Ertapenem Sodium), PRIMAXIN® (Imipenem and Cilastatin Sodium) and CANCIDAS® (Caspofungin Acetate)**  
**PO Box 8122 Somerville, NJ 08876**  
**Phone: 866-840-5400 FAX: 877-923-6786**

#### Application Process Checklist:

Application must be completed in full (both pages 1 & 2).

- Patient must sign the Patient/Applicant Authorization Section or Site must Indicate Patient Signature on File and available for audit
- Authorized Site Representative (Director Level or higher) must sign the Authorized Representative/Site Declaration Section.
- Attach Proof of Purchase of requested drug. The product NDC code must be on the proof of purchase documentation.  
**The proof of purchase must be within the last 24 months.**
- Attach Proof of Administration. **The proof of administration must be within the last 12 months.**
- If patient is self administering at home, additional documentation is required, please contact The Merck Hotline at 866-840-5400 to obtain the necessary forms.
- Fax completed application to: 877-923-6786 or
- Mail to: Merck Hotline for Invanz®, Primaxin® and Cancidas®, PO Box 8122, Somerville, NJ 08876
- After faxing or mailing you must keep the original application on file and available for auditing for a period of 3 years.
- Site and Patient records must be available for auditing. Audits will be scheduled in advance.

Patients that self administer at home:

- Additional documentation is required, please contact The Merck Hotline at 866-840-5400 to obtain the necessary forms.

#### Patient Eligibility:

- Patient cannot be eligible or have any prescription coverage at the time of administration. This includes Private, Medicaid, Medicare Part D and any other government programs.
- Patient must be a U.S. resident including Puerto Rico and US Territories.
- Patient must provide annual income and household dependents on the application.

#### Replacement Process:

- Invanz® and Primaxin® will be replaced based on a "full tray" distribution method. Product replacement will be provided when our records show that your facility has requested and been approved for the NDC Code equivalent of a full tray of product. For example: 10 vials for Invanz® and 10 or 25 vials for Primaxin®.
- Cancidas® will be replaced on single vial basis.
- Product will be sent to the site shipping address provided on your application.

#### Patient Information:

Patient Name: \_\_\_\_\_ Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

**Site of Service:**  Inpatient  Hospital Outpatient  Physician Office  Skilled Nursing Facility  Patient self administered  
 Other \_\_\_\_\_

Site Name: \_\_\_\_\_ Site DEA#: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Contact Name: \_\_\_\_\_

#### DRUG THERAPY (Please indicate product & number of vials)

Product Description	Replacement Quantity	NDC Code	# of Vials Requested
Cancidas® IV 50mg	10mL Vial	0006-3822-10	
Cancidas® IV 70mg	10mL Vial	0006-3823-10	
Invanz® 1g	Tray of 10 Vials	0006-3843-71	
Invanz® 1g in Add-Vantage	Tray of 10 Vials	0006-3845-71	
Primaxin® I.M. 500mg	Tray of 10 Vials	00006-3582-75	
Primaxin® I.V. 250mg	Tray of 25 Vials	00006-3514-58	
Primaxin® I.V 500mg	Tray of 25 Vials	00006-3516-59	
Primaxin® I.V. 250mg Add-Vantage	Tray of 25 Add-Vantage Vials	00006-3551-58	
Primaxin® I.V. 500mg Add-Vantage	Tray of 25 Add-Vantage Vials	00006-3552-59	
Primaxin® I.V. 500 in Monovial	Tray of 25 Monovial Vials	00006-3666-59	



**MERCK HOTLINE APPLICATION FOR INVANZ®, PRIMAXIN®, and CANCIDAS®**

**Patient Information:**

Patient Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: Male / Female

SS#: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

1. Does the patient have or qualify for prescription drug coverage in any government program? YES  NO
2. Does the patient have or qualify for prescription drug coverage in any private program? YES  NO
3. Is the patient a U.S. resident? YES  NO
4. What is the total ANNUAL household income, including Social Security and pension benefits? \$ \_\_\_\_\_
5. Number of household dependents? \_\_\_\_\_

**Primary Insurance**

Name Policy# Group #

(\_\_\_\_\_) \_\_\_\_\_

Phone Number Effective Date

Subscriber's Name Date of Birth

\_\_\_\_\_

Address \_\_\_\_\_

City State Zip

**Secondary Insurance**

Name Policy# Group #

(\_\_\_\_\_) \_\_\_\_\_

Phone Number Effective Date

Subscriber's Name Date of Birth

\_\_\_\_\_

Address \_\_\_\_\_

City State Zip

**Patient/Applicant Authorization**

I verify that the information provided in this application is complete and accurate and that without enrollment in the Merck Hotline for Invanz®, Primaxin® and Cancidas®, I would not be able to afford this medication. I authorize the Merck Hotline for Invanz®, Primaxin®, and Cancidas® and its administrators to obtain and disclose information from my prescribing physician and other information as necessary to complete the application process or verify the accuracy of any information provided in this application 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 application for the purpose of my participation in this program. I understand that Merck & Co. Inc., reserves the right at any time and without notice to modify the application form; modify or

10/15/2008

discontinue any or all programs; terminate assistance. I understand that signing this form does not ensure that I qualify for this program. I further certify that I will not seek reimbursement or credit from any insurer, health maintenance organization or government program. If I am a member of a Medicare Part D plan, I will not seek to have this medication or any cost associated with it counted as part of my expenditure or out-of-pocket cost for prescription drugs. I understand that my name, address, and any other personal identifying information provided in this application will be available to Merck, its affiliated companies, and its subcontractors, and that this information will not be disclosed to anyone else, except as required by law.

\_\_\_\_\_  
Patient's Signature Date

OR

**Patient's Signature on File? YES  NO  (Verified at audit)**

(MUST BE COMPLETED BY APPLICANT/AUTHORIZED REPRESENTATIVE OF SITE IF THE PATIENT'S SIGNATURE IS NOT PROVIDED)

**Site Shipping Address:**

Site Name: \_\_\_\_\_

Attention: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Physician Information**

Physician Name: \_\_\_\_\_

Physician DEA#: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Authorized Representative/Site Declaration**

I verify that the information provided on this application is complete and accurate. I understand that the patient must qualify financially and meet the program criteria to be eligible for assistance. I also understand that the product I request & receive is not a sample, but a replacement of inventory. I understand that I will not receive any reimbursement from Merck & Co., Inc., whether for administration fees or otherwise. Reimbursement for the product administered to the above patient on the date(s) indicate has not been sought and will not be sought from any source. Acceptance of this replacement product in no way obligates my facility to use Invanz®, Primaxin®, or Cancidas® for other patients. Additionally, I understand that Merck & Co. Inc., reserves the right to conduct periodic audits of hospital and patient records for those requests for product replacement. I accept that reasonable notice will be granted and audits will be conducted during regular business hours. I represent and warrant that this facility has obtained all applicable authorizations, consents, and notices necessary to comply with all federal and state laws and regulations relating in any way to medical and/or health privacy including but not limited to the HIPAA Privacy Rule, codified at 45 C.F.R Parts 160 and 164, as amended from time to time.

My signature confirms Invanz®, Primaxin® or Cancidas® was provided free of charge to this patient. I verify to the best of my knowledge the information set forth in this application is complete and accurate. I agree to retain a copy of this form in the facility's records and to make it available for auditing.

\_\_\_\_\_  
Authorized Representative (No Stamps Accepted) Date

\_\_\_\_\_  
Please Print Name Title