Thank you for downloading this prescription assistance document from NeedyMeds. We hope this program will help you get the medicine you need.

REMEMBER — Send your completed application to the address on the form, NOT to NeedyMeds.

Did you know that NeedyMeds has thousands of other free resources?

Here's a look at more ways we can help you save money on medicine and healthcare costs. Each one can be found under the **"Healthcare Savings"** tab on our website:

- **Diagnosis-Based Assistance** — NeedyMeds lists thousands of assistance programs for almost any health condition. If you are going through chemo treatment for cancer, there are programs that can help with wig costs and scalp-cooling products. We also list resources for free diabetes testing supplies, caregiver lodging support, and much more.
- **Free, Low-Cost, and Sliding Scale Clinics** — This popular collection contains information on 18,000+ free, low-cost, and sliding scale medical, dental, mental health and substance abuse clinics across the U.S. It's a great resource if you need affordable medical treatment and don't know where to go.
- **Coupons, Rebates & More** — You can use the NeedyMeds website to find 2,600+ cost-saving opportunities for both prescription and over-the-counter drugs and medical supplies.
- **Medical Transportation** — Need help getting to the doctor's office or medical facility? You may be eligible for financial assistance if you meet certain requirements.

NeedyMeds also offers information on diagnosis-based camps and retreats, recreational programs, scholarships, government programs, $4 generic drug programs, and more.

Finally, I want to tell you about the NeedyMeds Drug Discount Card. Thousands of people use this free, anonymous, and easy-to-use tool to get the best price on their medications. Use the card to get discounts on lab tests and also to save 40% on durable medical equipment. To date, our drug discount card has saved patients over $300,000,000. Check out the following page to learn more.

Feel free to call our toll-free helpline if you have any questions. We can be reached at 1-800-503-6897 Monday-Friday, 9am-5pm Eastern Time.

Thank you for using NeedyMeds. Please let us know if we can do anything else to help you afford the costs of your healthcare.

Rich Sagall, MD
President, NeedyMeds

Clip the card and save

NeedyMeds
NeedyMeds.org

DRUG DISCOUNT CARD

BIN: 020750
RX PCN: NMeds
RX GRP: PDFPDF
ID: NMNA019309901930

Customer Care
1-888-602-2978

This is a drug discount program, not an insurance plan.

NeedyMeds Drug Discount Card
www.needymeds.org

Patient: You may use this card at any of over 65,000 participating pharmacies to save on all prescription medicines. You cannot use this card with Medicare including part D, Medicaid, or any other state or federal programs unless you choose not to use your government-sponsored program. In addition, you cannot use this card with any health insurance program, but you can use it in place of your insurance if the card offers a better price. For questions call 1-888-602-2978 or visit www.drugdiscountcardinfo.com.

Pharmacist: Administered by Medical Security Company, LLC, Tucson, AZ.

Pharmacy Help Desk: 1-800-404-1031.

Powered by ScriptSave® WellRx

- Save up to 80% on medications*
- Use at over 65,000 pharmacies nationwide including all major chains
- Share the card with friends and family
- Use the card as often as needed
- Free, no fees or registration
- Never expires

What will receive a discount?

All prescription medications are eligible for savings, including over-the-counter medicines and medical supplies written as a prescription, as well as human-equivalent pet medications with a prescription by a veterinarian.

Save up to 40% off durable medical equipment, including canes, crutches, splints, incontinence supplies and more. You can also save on diabetic supplies such as glucose meters, test strips, lancets and diabetic shoes. Visit www.needymeds.org/dme to learn more.

You can also save an extra 5% on affordable lab tests and online results. No doctor's order or insurance needed. Visit www.needymeds.org/L2L for more information.

What if I have insurance?

Anyone can use the card, but it can't be combined with state or federal insurance. You can use the card instead of insurance if:

- A drug isn't covered by your insurance
- Your insurance has no drug coverage
- You have a high drug deductible
- You have met a low medicine cap
- The card offers a better price than your copay
- You are in the Medicare Part D donut hole

To obtain a plastic drug discount card, send a self-addressed, stamped envelope to:

NeedyMeds Drug Discount Card
50 Whittemore St.
Gloucester, MA 01930

The card is not valid in combination with insurance plans, including Medicare, Medicaid or any state or federal prescription insurance. The card can be used only if you decide not to use your government-sponsored drug plan for your purchases.

* Average savings of 60%, with potential savings of up to 80% or more (based on 2018 national program savings data). All prescription medications are eligible for savings.

This is a drug discount program, not an insurance plan. Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the type of prescription and the pharmacy chosen. This program does not make payments directly to pharmacies. Users are required to pay for all prescription purchases. Cannot be used in conjunction with insurance. You may call 1-888-602-2978 with questions or concerns or to obtain further information.

Reset Form

MERCK PATIENT ASSISTANCE PROGRAM ENROLLMENT FORM

Send completed and SIGNED forms to: Merck Patient Assistance Program, PO Box 690, Horsham, PA 19044-9979

For inquiries, please call 800-727-5400

PATIENT MUST COMPLETE THIS SIDE OF FORM AND SIGN IN BOTH PLACES WITH A SIGN

SECTION 1: COMPLETE THE PATIENT INFORMATION BELOW. PLEASE PRINT IN LEGIBLE CAPITAL LETTERS.

Use a Black or Blue Pen

Patient's First Name

US Resident* ☐ Yes ☐ No

*You do not have to be a US citizen

Last Name

Address

Apt. No.

City

State

ZIP

Phone

Date of Birth M M D D Y Y Y Y

Provide an e-mail address if you would like to be notified with an acknowledgement of enrollment form receipt

List current annual gross household income below.
(Your income before taxes)

Total Annual Income $

Number of Household Members (including patient)

Do you have insurance or other prescription drug coverage? Yes ☐ No ☐

☐ Medicare ☐ Medicaid ☐ Medicare Part D ☐ Other

I would like my product shipped to: ☐ My Home ☐ My Physician's Office

☐ Other Address:_____

Applicant Declarations and Authorization

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 this program. I certify that I cannot afford this medication. 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 Patient Assistance Program (PAP) reserves the right to modify the application form, modify or discontinue this program, or terminate assistance at any time and without notice. I understand that Merck PAP reserves the right to conduct periodic audits and to request documentation to verify the information provided in this application. 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 Section 2, 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 contained in Section 2 of this application form. I understand that assistance received through the Merck PAP is not insurance.

SIGN **Patient's Original Signature** _____ **Date** M M D D Y Y Y Y

Applicant Authorization for Use and Disclosure of Personal Health Information

By signing below, I authorize my health care provider(s) and my health plan(s), including Medicare, to disclose to the Merck Patient Assistance Program and other individuals involved in administering the Merck Patient Assistance Program (collectively, the "PAP") my personal health information, including the information provided by my health care provider on the PAP Application form and other information related to my participation in the PAP (collectively, "My Information"), so that the PAP may use the information to (i) assess my qualification for the PAP, (ii) provide me with PAP assistance, (iii) administer the PAP, (iv) monitor, audit, access and evaluate the PAP's implementation and effectiveness, and (v) contact me via mail, email, phone or fax for PAP-related purposes, including as part of PAP audits and to request additional information from me. I authorize the PAP to use My Information for the foregoing purposes, as well as to disclose My Information to auditors of the PAP and to my health plan(s), including Medicare, so that I may receive assistance from PAP if I am eligible. I understand that My Information, once disclosed pursuant to this authorization, may no longer be protected by federal law and could be re-disclosed to others, but I also understand that the PAP intends to use and disclose my Information only for the purposes stated herein. I understand that that I do not need to sign this Authorization in order to receive health care treatment or insurance benefits, but that if I do not sign the Authorization, I will not be able to obtain assistance from the PAP. I further understand that I may cancel the Authorization at any time by sending a written notice of cancellation by mail to: Merck Patient Assistance Program, PO Box 690, Horsham, PA 19044. I understand that if I cancel the Authorization, that will not invalidate uses and disclosures of My Information made in reliance on the Authorization before the PAP received notice of my cancellation. If I do not cancel it, the Authorization will remain in effect for 15 months from the date of my signature below (or the maximum period allowed by applicable state law, if less than 15 months). 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.

SIGN **Patient's Original Signature** _____ **Date** M M D D Y Y Y Y

PHYSICIAN/PRESCRIBER MUST COMPLETE THIS SIDE OF FORM AND SIGN IN BOTH PLACES WITH A SIGN

Use a Black or Blue Pen

SECTION 2: COMPLETE THE PRESCRIPTION AND PRODUCT INFORMATION BELOW.
PLEASE PRINT IN LEGIBLE CAPITAL LETTERS (enter only 1 Merck product per line).

THIS IS THE PRESCRIPTION. PLEASE DO NOT SUBMIT A PRESCRIPTION SEPARATE FROM THIS APPLICATION.*

Patient's First Name

Last Name

Date of Birth M M D D Y Y Y Y

Product 1 _____ Strength _____ Quantity _____ Directions _____ Refill ____ (1, 2, or 3) Times

Product 2 _____ Strength _____ Quantity _____ Directions _____ Refill ____ (1, 2, or 3) Times

Product 3 _____ Strength _____ Quantity _____ Directions _____ Refill ____ (1, 2, or 3) Times

Product 4 _____ Strength _____ Quantity _____ Directions _____ Refill ____ (1, 2, or 3) Times

Product 5 _____ Strength _____ Quantity _____ Directions _____ Refill ____ (1, 2, or 3) Times

Physician/Prescriber State License Number _____ Expiration Date of License: _____

SIGN ☐ Dispense As Written: **Physician/Prescriber's Signature** _____ (We cannot accept signature stamps)

ALLERGIES: ☐ None ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Penicillin ☐ Sulfa Other _____

MEDICAL CONDITIONS: ☐ None ☐ Asthma ☐ Glaucoma ☐ Heart ☐ High BP ☐ Ulcer Other _____

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

***NOTE: ALL CONTROLLED SUBSTANCE PRESCRIPTIONS MUST BE WRITTEN SEPARATELY FROM THE ENROLLMENT FORM.**

SECTION 3: PHYSICIAN/PRESCRIBER MUST COMPLETE, SIGN, AND DATE.

Physician's First Name M.I.

Physician's Last Name

Professional Designation

Name of Facility/Site

Mailing Address (PO Boxes not permitted)

Street Address

Suite/Bldg/Floor

City State ZIP

Office Phone Ext.

Secure Fax

Office Contact Name _____ Email Address _____

Physician/Prescriber Attestation

I certify that this prescription is medically appropriate for this patient 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 Merck PAP, its affiliated companies, or its subcontractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient. I understand that Merck PAP reserves the right to modify or discontinue this program at this facility/practice, or terminate assistance at any time and without notice. I certify that I will not seek reimbursement or credit for this prescription from any insurer, health plan, or government program. I understand that Merck PAP reserves the right to conduct periodic audits and to request documentation to verify the information provided in this application as it relates to Merck PAP for purposes of determining eligibility of the patient.

SIGN **Physician/Prescriber's Original Signature** _____ **Date** M M D D Y Y Y Y

This form should not be tampered with or revised in any way. Only originals with ink signatures will be accepted.
To report an adverse event to a specific Merck product, including death due to any cause, please contact the Merck National Service Center at 1-800-444-2080.