The Merck Access Program

HEALTHCARE PROVIDER ENROLLMENT FORM

KEYTRUDA® (pembrolizumab) Injection 100 mg

KEYTRUDA Qlex™ pembrolizumab + berahyaluronidase alfa-pmph
Subcutaneous Injection | 165 mg + 2,000 units/mL

Phone: 855-257-3932, Fax: 855-755-0518 or 480-663-4059 • The Merck Access Program, PO Box 2349, Columbus, OH 43216

TO ENROLL YOUR PATIENT IN THE MERCK ACCESS PROGRAM, COMPLETE THE HEALTHCARE PROVIDER ENROLLMENT FORM. IF THE PATIENT IS REQUESTING A REFERRAL TO THE MERCK PATIENT ASSISTANCE PROGRAM, PLEASE INCLUDE A PRESCRIPTION FOR *KEYTRUDA* OR *KEYTRUDA QLEX*.

PLEASE ENSURE THE PATIENT COMPLETES AND SUBMITS THE PATIENT ENROLLMENT FORM FOUND AT MERCKACCESSPROGRAM-KEYTRUDA.COM/KEYTRUDAQLEX/HCC.

PLEASE CHECK ALL BOXES THAT APPLY AND COMPLETE THE CORRESPONDING SECTION(S) REFLECTING THE SUPPORT REQUESTED BY YOUR PATIENT.

IF YOU DO NOT KNOW WHAT SUPPORT THE PATIENT IS REQUESTING, PLEASE CONSULT THE PATIENT.

Product (select **one**): ☐ KEYTRUDA ☐ KEYTRUDA QLEX
To avoid delays in processing, please select one product only

☐ Patient Benefit Investigation and/or information about the Prior Authorization (PA) or Appeals Process

☐ Merck Co-pay Assistance Program

☐ Referral to the Merck Patient Assistance Program for an eligibility determination (provided through the Merck Patient Assistance Program, Inc.*)

*Merck Patient Assistance Program, Inc. is a 501c3 Foundation and is separate and distinct from The Merck Access Program and the Merck Co-pay Assistance Program.

Please note: Upon receipt of this Enrollment Form, an additional worksheet may be sent to the healthcare professional contact on page 2 for completion.

PATIENT INFORMATION SECTION

PATIENT INFORMATION

Patient name: _____ Date of birth: _____

Address: _____ City/state/zip: _____

(Street address only, no PO boxes)

PATIENT INSURANCE INFORMATION

PLEASE COMPLETE ALL THAT APPLY AND **INCLUDE FRONT AND BACK COPIES OF INSURANCE CARD** FOR EACH TYPE OF INSURANCE

Is a Prior Authorization (PA) on file with the Payer? **Yes** ☐ **No** ☐ **AUTH #:** _____

Please include a copy of the PA Approval (if available).

Prior Authorization Approval Dates: _____

☐ **Patient Has No Insurance**

Patient Has Insurance Through Medicare:

Yes ☐ **No** ☐

(If Yes) ☐ **Part A** ☐ **Part B** ☐ **Part D** ☐ **Medicare Advantage**

	PRIMARY INSURANCE	SECONDARY INSURANCE	PRESCRIPTION INSURANCE
PLAN NAME AND STATE			
NAME OF POLICYHOLDER			
POLICYHOLDER DATE OF BIRTH			
POLICYHOLDER RELATION TO PATIENT			
PHONE NUMBER FOR CUSTOMER SERVICE			
GROUP NO.			
POLICY ID NO.			

Patient name: _____

HEALTHCARE PROVIDER INFORMATION SECTION

HEALTHCARE PROVIDER INFORMATION (to be completed by healthcare provider)

Healthcare provider name: _____

Healthcare provider tax ID no.: _____

Healthcare provider NPI no.: _____

Healthcare provider state license no.: _____ Expiration date: _____

Address: _____

(Street address only, no PO boxes)

City/state/zip: _____

Phone: _____ Ext: _____

Fax: _____

Office contact person: _____

Office contact number: _____ Ext: _____

Email: _____

Please indicate benefit preference: ☐ Medical ☐ Pharmacy

☐ Buy and Bill (medical) ☐ On-site pharmacy ☐ Specialty pharmacy

Pharmacy name: _____

Pharmacy address: _____

Practice/Facility name: _____

Practice tax ID no.: _____

Practice NPI no.: _____

Practice/Facility address: _____

(Street address only, no PO boxes)

City/state/zip: _____

Please list primary diagnosis code and description:

_____

Please code to the highest level of specificity. Use of an unspecified code may delay the MAP Enrollment Process.

Product use is consistent with labeled indications for prescribed product (KEYTRUDA or KEYTRUDA QLEX):
Yes ☐ **No** ☐

Please refer to the Prescribing Information for KEYTRUDA or KEYTRUDA QLEX for a full list of indications

☐ **Monotherapy** ☐ **In combination with:** _____
Next treatment date: _____

Pharmacy phone: _____

Pharmacy fax: _____

THE MERCK CO-PAY ASSISTANCE PROGRAM TERMS AND CONDITIONS

The Merck Co-pay Assistance Program for KEYTRUDA® (pembrolizumab) Injection 100 mg or KEYTRUDA QLEX™ (pembrolizumab and berahyaluronidase alfa-pmph) Injection 165 mg + 2,000 units/mL (each individually, a "Program Product").

To receive benefits under the Co-pay Assistance Program, the patient must enroll in the Co-pay Assistance Program and be accepted as eligible. A patient's eligibility for the Co-pay Assistance Program will commence upon the date of The Merck Access Program's acceptance of patient's enrollment and will continue for twelve months thereafter ("Eligibility Period"), so long as the patient satisfies all eligibility criteria of the Co-pay Assistance Program for each date of administration of the Program Product.

- Patient must be prescribed the Program Product for an FDA-approved indication.
- Patient must have private health insurance that provides coverage for the cost of the Program Product under a medical benefit plan or a pharmacy benefit plan.
- **The Co-pay Assistance Program is not valid for patients covered under Medicaid (including Medicaid patients enrolled in a qualified health plan purchased through a health insurance exchange [marketplace] established by a state government or the federal government), Medicare, a Medicare Part D or Medicare Advantage plan (regardless of whether a specific prescription is covered), TRICARE, CHAMPUS, Puerto Rico Government Health Insurance Plan ("Healthcare Reform"), or any other state or federal medical or pharmaceutical benefit program or pharmaceutical assistance program (collectively, "Government Programs"). The Co-pay Assistance Program is not valid for uninsured patients.**
- Patient must be a resident of the United States or the Commonwealth of Puerto Rico. Product must originate and be administered to patient in the United States or the Commonwealth of Puerto Rico.
- **Subject to changes in state law, the Co-pay Assistance Program may become invalid for residents of Massachusetts prior to its expiration date.**
- All information applicable to the Co-pay Assistance Program requested on The Merck Access Program Enrollment Form must be provided, and all certifications must be signed. Forms that are modified or do not contain all the necessary information will not be eligible for benefits under the Co-pay Assistance Program.
- **Patient must pay the first $25 of co-pay per administration of Program Product.** The benefit available under the Co-pay Assistance Program is limited to the amount indicated on the documentation provided by the patient's private health insurance company, which can include, but is not limited to, an Explanation of Benefits (EOB) or a Remittance Advice (RA), that the patient is obligated to pay for the Program Product, less $25, up to the Co-pay Assistance Program per patient maximum. The maximum Co-pay Assistance Program benefit per patient per Eligibility Period is $25,000.
- Patient must have an out-of-pocket cost for the Program Product and be administered the Program Product during the patient's Eligibility Period or the 90-Day Lookback Period (defined below) **AND** during the Term (defined below) of the Co-pay Assistance Program. The benefit available under the Co-pay Assistance Program is valid for the patient's out-of-pocket cost for the Program Product only. It is not valid for any other out-of-pocket costs (for example, office visit charges or medication administration charges) even if such costs are associated with the administration of the Program Product. The claim for Program Product must be submitted by the patient's healthcare provider or pharmacy (both referred to as "Provider") to patient's private health insurance separately from other services and products.
- To receive the benefit available under the Co-pay Assistance Program, patient or Provider must submit documentation provided by the patient's private health insurance company that contains the following information: name of the patient's private health insurance company, patient's insurance plan details (patient ID, policy/group/payor ID, and, for pharmacy benefit claims only, BIN and PCN); patient's demographic information (full name, date of birth, and address); patient's out-of-pocket cost for Program Product; confirmation that the Program Product was administered to the patient; date of Program Product administration to the patient; and submission of the claim by the Provider for the cost of the Program Product. The documentation must also show that the Program Product was paid separately from other services and products.
- The documentation provided by the patient's private health insurance company, which can include, but is not limited to, an EOB or RA, must be submitted to the Co-pay Assistance Program within **180 days** of the date the claim was processed for patient to receive a co-pay assistance benefit; provided, however, that no claims may be submitted more than **180 days** after the expiration date of the Co-pay Assistance Program.
- The Co-pay Assistance Program may apply to patient out-of-pocket costs incurred for a Program Product that was administered **up to 90 days** prior to the start date of the patient's Eligibility Period ("90-Day Lookback Period"), subject to the Co-pay Assistance Program per patient maximum and the applicable Terms and Conditions based on Program Product administration date. Patient or Provider may contact The Merck Access Program for more information. The 90-Day Lookback Period does not apply to KEYTRUDA QLEX™ (pembrolizumab and berahyaluronidase alfa-pmph) prior to the initial FDA approval date.
- Patient and Provider agree not to seek reimbursement for all or any part of the benefit received by the patient through the Co-pay Assistance Program. Patient and Provider are responsible for reporting receipt of Co-pay Assistance Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Co-pay Assistance Program, as may be required.
- No other purchase is necessary.
- **The Co-pay Assistance Program is not insurance.**
- The Merck Access Program Enrollment Form may not be sold, purchased, traded, or counterfeited. Void if reproduced.
- The Co-pay Assistance Program is void where prohibited by law, taxed, or restricted. The Co-pay Assistance Program is not transferable. No substitutions are permitted.
- The Co-pay Assistance Program benefit cannot be combined with any other Co-pay Assistance Program, free trial, discount, prescription savings card, or other offer.
- If acquiring Program Product from a Specialty Pharmacy (to be later administered in a physician office or outpatient institution), additional documentation may be required.
- Merck reserves the right to rescind, revoke, or amend the Co-pay Assistance Program at any time without notice.
- Data related to patient's receipt of Co-pay Assistance Program benefits may be collected, analyzed, and shared with Merck, for market research and other purposes related to assessing Co-pay Assistance Programs. Data shared with Merck will be aggregated and de-identified, meaning it will be combined with data related to other Co-pay Assistance Program redemptions and will not identify patient.
- The term of the Co-pay Assistance Program is from September 23, 2025, through September 30, 2027 ("Term"). A patient may have only one Eligibility Period during the Term of the Co-pay Assistance Program. Enrollment into the Co-pay Assistance Program will automatically terminate patient's eligibility in any other Merck Co-pay Assistance Program for Program Product.
- **Program Group Number: 2456, Expiration Date: 09/30/2027**

Patient name: _____

HEALTHCARE PROVIDER INFORMATION SECTION

HEALTHCARE PROVIDER CERTIFICATION: THE MERCK CO-PAY ASSISTANCE PROGRAM

I, a licensed healthcare professional, certify that KEYTRUDA® (pembrolizumab) Injection 100 mg or KEYTRUDA QLEX™ (pembrolizumab and berahyaluronidase alfa-pmph) Injection 165 mg + 2,000 units/mL (each individually, a "Program Product") has been prescribed to the patient indicated on The Merck Access Program Enrollment Form in the exercise of the prescriber's independent medical judgment for an FDA-approved indication.

I have read and agree to the Terms and Conditions of the Merck Co-pay Assistance Program. I certify that, to the best of my knowledge, the patient meets the criteria set forth in the Terms and Conditions, and that the information I am providing is true and correct.

I certify that I/my facility will not take into account the fact that the patient may receive a benefit from the Co-pay Assistance Program when determining the amount of any charge(s) to the patient.

I certify that I/my facility will not charge the patient any fee to complete The Merck Access Program Enrollment Form and I/my facility will not advertise or otherwise use the Co-pay Assistance Program as means of promoting my services or the Program Product.

I certify that the claim I submit/my facility submits to the patient's private health insurer for payment of the Program Product will have the Program Product listed separately from any claim for medication administration or any other items or services provided to the patient.

I understand that I am/my facility is responsible for reporting receipt of Co-pay Assistance Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Co-pay Assistance Program, as may be required.

I certify that I/my facility will not seek reimbursement for all, or any part of, the benefit received by the patient through the Co-pay Assistance Program.

I understand that the patient's benefit received under the Co-pay Assistance Program will be paid directly to me/my facility by the Co-pay Assistance Program on behalf of my patient. I/my facility will apply any amounts received from the Co-pay Assistance Program to the satisfaction of the patient's obligation for the cost of the Program Product only. If I/my facility already received payment from the patient for the patient's share of the cost of the Program Product for which the patient receives a benefit through the Co-pay Assistance Program, I/my facility will refund the amounts received (minus the patient's obligation per administration in accordance with the Co-pay Assistance Program Terms and Conditions) back to the patient.

I understand and agree that the certifications I am providing in this Healthcare Provider Certification apply to the patient indicated on The Merck Access Program Enrollment Form and to any other patient enrolled in the Co-pay Assistance Program whom I treat with the Program Product and any claim I submit/my facility submits for Co-pay Assistance Program benefits on the patient's behalf.

I understand that I may be asked to sign a new Healthcare Provider Certification if the Terms and Conditions of the Co-pay Assistance Program for the Program Product change.

HEALTHCARE PROVIDER ATTESTATION

I represent and warrant that I or others in my practice ("my Practice") have obtained written authorization from the patient listed above (the "Patient") that complies with the HIPAA Privacy Rule, authorizes me, my Practice, and the Patient's health insurance plan(s), to disclose the Patient's protected health information ("PHI") to The Merck Access Program and the Merck Patient Assistance Program (together, "the Programs"), Merck Sharp & Dohme LLC, and each of their employees, affiliates, representatives, agents, contractors, and data processors, including the administrators of the Programs (collectively, "Merck"), and authorizes Merck to use and disclose the PHI for purposes of the Programs, including to provide benefits investigation and reimbursement support, and for Merck's related internal business purposes. If my Practice uses a Third-Party Administrator (TPA), I represent and warrant that the TPA is authorized to submit enrollment forms to Merck on my behalf, has been trained on the Merck Programs' rules and requirements, and will not sign any documents on behalf of the Patient. I represent and warrant that I am authorized under the laws of my state of license to prescribe KEYTRUDA and/or KEYTRUDA QLEX, that I have determined that KEYTRUDA or KEYTRUDA QLEX is medically appropriate for the Patient, and that I will supervise the Patient's treatment. I certify that the Program Product is being used in an outpatient setting only. If the Patient receives KEYTRUDA or KEYTRUDA QLEX through the Merck PAP, neither I nor my Practice will receive any reimbursement from Merck, whether for administration fees or otherwise any source. I understand that any donated product from Merck PAP must be returned if the specific eligible patient is unable to receive treatment for any reason and may not be used for any other patient other than the Merck PAP patient for whom it was intended. I and my Practice grant the Programs the right to conduct periodic audits of my Practice's records to verify the information provided herein.

I consent to receive communications related to the Programs by telephone, email, and/or fax.

By signing, I certify that I have read and agree to the above Healthcare Provider Attestation and the information provided is complete and accurate to the best of my knowledge.

HEALTHCARE PROVIDER SIGNATURE

Healthcare provider signature: _____ Date: _____

Healthcare provider name (please print): _____

Healthcare provider designation (MD, DO, NP, PA, Other): _____

To report a suspected adverse event involving a specific Merck product, please contact the Merck National Service Center at 800-444-2080.

MERCK

THE MERCK ACCESS PROGRAM
PHONE: 855-257-3932, FAX: 855-755-0518 or 480-663-4059