GARDASIL® 9
Human Papillomavirus
9-valent Vaccine, Recombinant

The Merck Access Program
ENROLLMENT FORM

Phone: 855-210-1965 **Fax:** 833-404-4901 • The Merck Access Program, PO Box 29067, Phoenix, AZ 85038

TO GET STARTED, COMPLETE THE REQUIRED FIELDS ON PAGE 1, REVIEW THE PATIENT AUTHORIZATION ON PAGES 2 AND 3, THEN SIGN AND DATE THE FORM. A MERCK ACCESS PROGRAM (MAP) REPRESENTATIVE WILL CALL YOU TO DISCUSS YOUR INSURANCE COVERAGE. PLEASE ANSWER CALLS FROM 855-210-1965.

PATIENT INFORMATION

Patient name:_____ Date of birth (mm/dd/yyyy):_____

Address:_____ City/state/zip:_____
(Street address only, no PO boxes)

Phone (home):_____ (work):_____ (other):_____

Email:_____

Please indicate where you plan to receive your vaccine: ☐ At a healthcare provider's office/clinic ☐ At a pharmacy

Healthcare Provider or Pharmacy Name: _____ Phone Number: _____

INSURANCE INFORMATION

Please provide your insurance plan information in the boxes below. MAP will verify whether you have coverage through your medical and/or prescription insurance plans, as applicable.

	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 AUTHORIZATION

I understand that, before I may have communications with The Merck Access Program, sponsored by Merck Sharp & Dohme LLC ("Merck"), a subsidiary of Merck & Co., Inc., ("a Program"), the administrators of the Program, including their contractors or other representatives, will need to obtain, review, use, and disclose my personal health information ("PHI"), including information relating to my medical condition and prescription medications and the information included in this patient enrollment form.

I therefore authorize each of my physicians, pharmacies, and health plans to disclose my PHI, as necessary, to the administrators of the Program and their contractors or representatives, in order to verify my eligibility to enroll in the Program and to enroll me in the Program if I am eligible.

I also authorize the administrators of the Program and their contractors or representatives to (i) use my PHI to provide the services described in this enrollment form, including to communicate with me by U.S. postal mail, telephone, text, or e-mail and to prepare summaries that do not include my PHI for statistical purposes; and (ii) share my PHI with one another and with my physicians and pharmacists as well as with Medicare, my health plans, and their administrators, contractors, or representatives, in order for them to coordinate my benefits, provide, when applicable, reimbursement support, and investigate my insurance coverage.

I also authorize the administrators of the Program and their contractors, representatives, and third-party services partners to disclose my PHI to authorized representatives of Merck as necessary to ensure compliance with the rules of the Program. I also authorize Merck's authorized representatives to use my PHI to communicate with the administrators of the Program, their contractors, representatives or third-party services partners, my physicians, pharmacies, and me for compliance purposes.

If I have designated a Personal Representative, I authorize the Program, their administrators, and their third-party services partners to use my PHI to contact the person I have designated as my Personal Representative for the purpose of verifying the information I have provided in this form and/or coordinating the provision of benefits that may be available to me under the Program and to disclose my PHI, including information provided in this enrollment form, to my Personal Representative for the purposes described in this paragraph.

PATIENT AUTHORIZATION (*continued*)

I understand that the PHI disclosed pursuant to this authorization, once disclosed, may not be governed by federal or state privacy laws and may be subject to re-disclosure, but I also understand that the administrators of the Program and their contractors and other representatives intend to use and disclose my PHI only for the purposes described in this authorization. I further understand that if I choose not to provide this authorization, it will not affect my eligibility for, or receipt of, treatment, including Merck products, or healthcare insurance benefits, but that I will not be able to receive any assistance from the Program if I may be eligible.

I understand that I may cancel this authorization at any time by telephoning The Merck Access Program at (855) 210-1965 or by mailing a written request for cancellation to The Merck Access Program, PO Box 29067, Phoenix, AZ 85038. I understand that canceling my authorization will mean that my physicians, pharmacies, and health plans, as well as the Program, their administrators, and their contractors and representatives, may no longer rely on the authorization to use or disclose my PHI, but that any use or disclosure of such information that occurs before my cancellation is received will be unaffected by my cancellation.

I understand that if I do not cancel this authorization, the authorization will expire 15 months from the date of signature (or the maximum period allowed by applicable state law, if less than 15 months). The administrators of the Program will retain the information I have submitted in accordance with Merck's records retention policy.

I understand that I am entitled to receive a copy of this authorization once it has been signed.

By signing, I certify that I have read and agree to the above Patient Authorization.

REQUIRES SIGNATURE

Signature of patient or legal representative:_____ Date:_____

Name of signing party (please print):_____

Relationship to patient (if other than patient signing): _____

MERCK