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 ENROLLMENT FORM AND SUBMIT ONLINE, OR PRINT AND FAX THE COMPLETED DOWNLOADABLE FORM TO 833-404-4901.

PATIENT INFORMATION SECTION

PATIENT INFORMATION

Patient is a US resident Yes ☐ No ☐

Patient name:_____ Date of birth:_____ Sex: M ☐ F ☐

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

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

E-mail:_____

INSURANCE INFORMATION

PLEASE COMPLETE ALL THAT APPLY AND INCLUDE A FRONT AND BACK COPY OF INSURANCE CARD FOR EACH TYPE OF INSURANCE

☐ **Patient Has No Insurance** **Patient Has Insurance Through Medicare:** ☐ **Part A** ☐ **Part B** ☐ **Part C** ☐ **Medicare Advantage**

Primary insurer (including Medicaid, Medicare, veterans' benefits, and private insurers)

Plan name and state:_____

Phone number for customer service:_____ Name of policyholder:_____

Policyholder date of birth:_____ Policyholder relation to patient:_____

Group no.:_____ Policy ID no.:_____

Secondary/supplemental insurer

Plan name and state:_____

Phone number for customer service:_____ Name of policyholder:_____

Policyholder date of birth:_____ Policyholder relation to patient:_____

Group no.:_____ Policy ID no.:_____

Patient name:_____

HEALTH CARE PROVIDER INFORMATION SECTION

HEALTH CARE PROVIDER INFORMATION (to be completed by health care provider)

Health care provider name:_____

Health care provider tax ID no.:_____

Health care provider NPI no.:_____

Health care provider state license no.:_____

Health care provider state license no. expiration date:_____

Address:_____
(Street address only, no PO boxes)

City/state/zip:_____

Phone:_____ Fax:_____

E-mail:_____

Office contact person:_____

Office contact number:_____

Practice/Facility name:_____

Practice tax ID no.:_____

Practice NPI no.:_____

Practice/Facility address:_____
(Street address only, no PO boxes)

City/state/zip:_____

Planned 9-valent HPV vaccination date:_____

Has the patient received previous doses of GARDASIL®9 (Human Papillomavirus 9-valent Vaccine, Recombinant)? Yes ☐ No ☐

If the patient has received previous doses of GARDASIL 9, please indicate the dates of administration (leave blank if no doses have been administered):

Dose 1:_____

Dose 2:_____

Site of Care:
- ☐ **Hospital outpatient department**
- ☐ **Health care provider office/clinic**
- ☐ **Pharmacy**
- ☐ **Other:**_____

HEALTH CARE PROVIDER ATTESTATION

By signing below, I represent and warrant the following:

- This Enrollment Form has been prepared exclusively by the health care provider or health care provider office identified in this Enrollment Form.
- By signing below, I represent and warrant that I am authorized pursuant to the laws of my state of license to prescribe vaccines.
- I or others in my health care provider practice group ("my Practice") have obtained written authorization from the patient named in this Enrollment Form that complies with the requirements of the HIPAA Privacy Rule, 45 C.F.R. § 164.508, and authorizes me and the Practice, as well as the patient's health insurance plan(s), to disclose the patient's personal health information ("PHI"), including information relating to the patient's medical condition and prescription medications and the information disclosed in this Enrollment Form to The Merck Access Program (the "Program"), and authorizes the Program, including its contractors or other affiliates, to use and disclose the PHI for purposes of benefits investigation and reimbursement support.
- I certify that I, or a health care provider in my Practice, have determined that the prescribed product is medically appropriate for the patient identified above and that I, or a health care provider in my Practice, will be supervising the patient's treatment.
- Neither I nor my Practice will receive any reimbursement from Merck, whether for administration fees or otherwise.
- I understand that information concerning program participants may be summarized for statistical or other purposes and provided to Merck and/or the Program.
- I and my Practice grant the Program the right to conduct periodic audits of my Practice's records to verify the information provided herein, excluding patient-identifiable data (unless the auditor enters into an appropriate agreement with the Practice to protect an individual's medical privacy).
- I consent to receive communications related to the Program by telephone, e-mail, and/or fax.
- I understand that the Program reserves the right to modify or discontinue this program at this facility/practice, or terminate assistance at any time and without notice.
- The information provided is complete and accurate to the best of my knowledge.

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

HEALTH CARE PROVIDER SIGNATURE

Health care provider's signature:_____ **Date:**_____

Health care provider's name (please print):_____

Health care provider designation (MD, DO, NP, PA, other):_____

To report an adverse event to a specific Merck product, including death due to any cause, please contact the Merck National Service Center at 800-444-2080.

MERCK