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 FAX IT TO 833-404-4901.

PATIENT INFORMATION SECTION

PATIENT INFORMATION

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

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

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

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**

Primary 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.:_____

Secondary 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)

Provider name:_____

Provider tax ID no.:_____

Provider NPI no.:_____

Provider license no.:_____

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

City/state/zip:_____

Phone:_____ Fax:_____

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**
☐ **Physician office/clinic**
☐ **Pharmacy**
☐ **Other:**_____

HEALTH CARE PROVIDER AUTHORIZATION

MUST CONTAIN ORIGINAL SIGNATURE

By signing below, I represent and warrant the following:

- This request has been prepared exclusively by the health care provider or health care provider office identified in this request ("my Practice").
- I certify that I am authorized pursuant to state law to prescribe vaccines, either alone or in tandem with a collaborating physician.
- My Practice has obtained written authorization from the patient identified in this request 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 patient enrollment form, as well as the information included in this request, to The Merck Access Program, sponsored by Merck Sharp & Dohme Corp. ("Merck"), a subsidiary of Merck & Co., Inc. ("the Program"), the administrator of the Program, McKesson Specialty Arizona, Inc. ("McKesson"), including their contractors or other affiliates, and for the Program to use and disclose the information for the purposes of benefits investigation and reimbursement support.
- My Practice has provided the patient identified in this request with the notices necessary to comply with all federal and state laws and regulations relating 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.
- I certify that I, or a physician in my Practice, have determined that the prescribed product is medically appropriate for the patient identified above.
- I also understand that 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 understand that the Program reserves 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 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.
- I verify that the information provided is complete and accurate to the best of my knowledge.

I certify that I have read and agree to the above authorization and certification.

HEALTH CARE PROVIDER SIGNATURE

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

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

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