



Patient First, Last Name: \_\_\_\_\_

**SECTION 2: Licensed Prescriber Information** (Healthcare provider should complete Sections 2 and 3.)

First, Last Name: \_\_\_\_\_

Practice/Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Note: The address you provide above is where Merck will ship the replacement dose.

**Type of Licensed Prescriber:**  Physician  Nurse Practitioner  Physician Assistant  Certified Nurse Midwife

**State License Number: #** \_\_\_\_\_ (must be active and valid)

Is this patient seeing you at a public practice, (ie, one that is wholly owned and operated by the government)?

Yes  No

Office Contact Person: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

I have a Merck Direct Account. Account Number: # \_\_\_\_\_

I don't have a Merck Direct Account.

**SECTION 3: Vaccine Information**

**Merck Vaccine Product Name:** \_\_\_\_\_ **NDC Number: #** \_\_\_\_\_

If GARDASIL® [Human Papillomavirus Quadrivalent (Types 6, 11, 16, and 18) Vaccine, Recombinant], indicate:  Dose 1  Dose 2  Dose 3

**Have you administered this dose?**  Yes  No

**To be completed after application is approved by a Merck Vaccine Patient Assistance Program Representative.**

**Confirmation Number: #** \_\_\_\_\_

**Date of Administration:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Merck Vaccine Lot Number: #** \_\_\_\_\_

**IMPORTANT:** The confirmation number is valid for **30 days**. If the vaccine dose is not administered to the eligible patient within 30 days following when it was granted, then the patient must submit a new application. The office must provide the date of administration and lot number to the Merck Vaccine Patient Assistance Program for all approved doses of vaccine in order for replacement product to be provided.

Merck will replace the doses of vaccine administered to approved patients via quarterly shipments to the licensed prescriber. [Notes: Merck retains the right to select either prefilled syringes or vials for replacement doses which may or may not be the same as what was administered to approved patients. M-M-R® II (Measles, Mumps, and Rubella Virus Vaccine Live) and PNEUMOVAX®23 (Pneumococcal Vaccine Polyvalent) are not available in single-dose units; therefore, these vaccines can be shipped only when the minimum threshold is reached.

**Licensed Prescriber Declarations**

I verify that the information provided on this application is complete and accurate. I understand that the patient must be part of the population for which the administered vaccine is indicated and I certify that this vaccine is medically indicated for this patient.

I understand that the patient must qualify financially and meet the program criteria to be eligible for assistance.

The product administered to the above patient on the date(s) above will be considered a donation to the patient from the Merck Vaccine Patient Assistance Program. I also understand that the product I receive is not a sample, but a replacement of product I previously purchased. I understand that I will not receive any reimbursement from Merck & Co., Inc., whether for administration fees or otherwise. I will not seek reimbursement for administration of vaccine from any public payer. Additionally, reimbursement for the cost of the product administered to the above patient on the date(s) above has not been sought and will not be sought from any source.

I understand that Merck & Co., Inc., reserves the right to conduct periodic audits of the records, excluding patient-identifiable data (unless the auditor enters into an appropriate relationship with the facility to protect an individual's medical privacy), of all entities receiving replacement of inventory in connection with the Merck Vaccine Patient Assistance Program. I accept that reasonable notice will be granted and audits will be conducted during regular business hours.

I represent and warrant that this facility has obtained all applicable authorizations, consents, and notices necessary to comply with all federal and state laws and regulations relating in any way 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.

My signature below confirms that the vaccine product will be provided free of charge to this individual. I verify that to the best of my knowledge the information set forth in this application is complete and accurate. I agree to retain a copy of this form in the facility's records and to make it available to the Internal Revenue Service upon request.

**Licensed Prescriber's**

**Original Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(No stamps accepted)