

Important Steps for Patient and Physician/Prescriber:

1. Complete ALL information on the application form.
You may fill in the fields online and print it.
OR
You may print out the form and fill it out by hand using a black ballpoint pen.
2. Take the completed application to your physician/prescriber. **Both the physician/prescriber and the patient MUST sign the application.**
3. Have your physician/prescriber write your prescription(s) in Section 2 of the application.
 - A single application may include prescriptions for up to **3** Merck medicines.
 - Each prescription may not exceed a 90-day supply at a time, with a maximum of **3 refills**.
 - Each application is valid for up to 12 months; after **12 months** a new application will be required. Under certain circumstances, enrollment may be limited to a calendar year.
 - A separate Merck Patient Assistance Program application is **REQUIRED** for **each** patient.
4. Mail **completed** applications to:

**Merck Patient Assistance Program
PO Box 690
Horsham, PA 19044-9979**

Please Note:

- Incomplete or incorrectly completed applications will be returned.
- **Section 2 is your prescription. There is no need to write your prescription on a separate prescription form.**
- Patient's prescription will be sent to the patient's home address unless otherwise requested by the physician/prescriber in Section 3 of the application.
- For additional applications or assistance, please call 1-800-727-5400.

SECTION 2: THIS IS THE PRESCRIPTION. PHYSICIAN SHOULD COMPLETE THE PRESCRIPTION AND PRODUCT INFORMATION BELOW. PLEASE PRINT. (PLEASE DO NOT SUBMIT A PRESCRIPTION SEPARATE FROM THIS APPLICATION.)

Patient's First Name M.I.

Last Name

Date of Birth
M M D D Y Y Y Y

Product Name _____ Strength _____ Quantity _____ Directions _____ Refill ____ (1, 2, or 3) Times

Product Name _____ Strength _____ Quantity _____ Directions _____ Refill ____ (1, 2, or 3) Times

Product Name _____ Strength _____ Quantity _____ Directions _____ Refill ____ (1, 2, or 3) Times

State License Number _____ Date _____

Check appropriate box below:

- Dispense As Written: Physician/Prescriber's Signature _____ (We cannot accept signature stamps)
- Substitution Permissible: Physician/Prescriber's Signature _____ (We cannot accept signature stamps)

ALLERGIES: None Aspirin Codeine Iodine Penicillin Sulfa Other _____

MEDICAL CONDITIONS: None Asthma Glaucoma Heart High BP Ulcer Other _____

CURRENT MEDICATION(S) BEING TAKEN BY THE PATIENT: _____

SECTION 3: COMPLETE THE PHYSICIAN/PRESCRIBER INFORMATION BELOW AND SIGN THE FOLLOWING STATEMENT.

Physician's First Name M.I.

Last Name

Professional Designation

Site

Address (no PO Box No.)

(Bldg/Suite)

City

State ZIP

Phone - - Ext.

Secure Fax - -

Ship Product to: Physician's Office Patient's Home

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Physician/Prescriber Attestation

I certify that this prescription is medically indicated for this patient and that I will be supervising the patient's treatments. I verify that the information provided is complete and accurate to the best of my knowledge. I authorize Merck, its affiliated companies, or its subcontractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient.

Physician's/Prescriber's Original Signature _____

Date
M M D D Y Y Y Y