THE MERCK ACCESS PROGRAM

HEALTHCARE PROVIDER ENROLLMENT FORM

WELIREG™ (belzutifan) 40 mg tablets

Before prescribing WELIREG, please read the accompanying Prescribing Information, including the Boxed Warning about embryo-fetal toxicity. The Medication Guide also is available.

Phone: 855-257-3932 Fax: 855-755-0518 • The Merck Access Program, PO Box 2349, Columbus, OH 43216

Prescriptions for WELIREG can be filled through EITHER the specialty pharmacy network or certain physician practices with dispensing capabilities and certain hospital pharmacies. Please select the appropriate option below for how your patients can obtain WELIREG.

Specialty Pharmacy Network

Option 1: If a specialty pharmacy has referred your patient to The Merck Access Program (MAP) to determine eligibility for PAP, please select which pharmacy made the referral:

☐ Biologics Pharmacy ☐ Onco360 Oncology Pharmacy

Please complete sections 2–4, as applicable, to have your patient referred to the Merck PAP for eligibility determination.

Certain Physician Practices With Dispensing Capabilities & Certain Hospital Pharmacies

Option 2: If your facility is dispensing WELIREG, please check all boxes below that apply.

☐ Patient Benefit Investigation and/or information about the Prior Authorization or Appeals Process

☐ Referral to the Merck PAP for eligibility determination (provided through the Merck Patient Assistance Program, Inc.)

Please complete sections 1–4, as applicable, to enroll your patient in The Merck Access Program (MAP).

Section 1: Insurance Information

INSURANCE INFORMATION (REQUIRED)

Please complete all that apply and include a front and back copy of insurance card for each type of insurance.

Is Prior Authorization on file with the Payer? ☐ Yes ☐ No AUTH #: _____

PA Approval Dates: _____

☐ Patient has no insurance

☐ Patient has insurance through Medicare: ☐ Yes ☐ No

(If yes:) ☐ Part A ☐ Part B ☐ Part D ☐ Medicare Advantage

	PRIMARY INSURANCE	SECONDARY 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.		

Section 2: Patient Information

PATIENT INFORMATION

Patient is a US resident: ☐ Yes ☐ No

Patient name: _____ Date of birth (mm/dd/yy): _____ Sex: ☐ M ☐ F

Address: _____ City/state/zip: _____

(Street address only, no PO boxes)

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

Email: _____

Section 3: Healthcare Provider Information

HEALTHCARE PROVIDER INFORMATION (to be completed by healthcare provider)

Healthcare provider name: _____

Healthcare provider tax ID #: _____ Healthcare provider NPI #: _____

Practice/Facility name: _____ Practice tax ID #: _____

Practice NPI #: _____

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

Phone: _____ Fax: _____

Office contact person: _____ Office contact number: _____

Email: _____

Product use is consistent with labeled indications for WELIREG™ (belzutifan): ☐ Yes ☐ No

Section 4: Healthcare Provider Attestation

HEALTHCARE PROVIDER ATTESTATION

By signing below, I represent and warrant the following:

- This Enrollment Form has been prepared exclusively by the healthcare provider or healthcare 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 WELIREG.
- I or others in my healthcare 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 "Access Program") and the Merck Patient Assistance Program ("Merck PAP") (collectively, "the Programs") and the administrator of Merck's field access and reimbursement support team, including its contractors, representatives, or third-party services partners (collectively, "Field Access and Reimbursement Support Administrator"), and authorizes the Programs and Field Access and Reimbursement Support Administrator (together with their respective administrators, contractors or other affiliates) to use and disclose the PHI for purposes of benefits investigation and reimbursement support.
- I represent and warrant that if my Practice uses a Third-Party Administrator (TPA), the TPA is authorized to act on my behalf to submit enrollment forms to Merck PAP and that the TPA has been trained on Merck PAP rules and requirements before providing services related to Merck PAP.
- I understand that a TPA may not sign on behalf of the patient.
- I certify that I, or a healthcare provider in my Practice, have determined that the prescribed product is medically appropriate for the patient identified above and that I, or a healthcare provider in my Practice, will be supervising the patient's treatment.
- I certify that the Program Product is being used in an outpatient setting only.

HEALTHCARE PROVIDER ATTESTATION

- If the patient receives product through the Merck PAP, neither I nor my Practice will seek reimbursement for such product administered to the patient from any source.
- I understand that any donated product from Merck PAP must be returned if the specific eligible patient is unable to receive treatment for any reason and may not be used for any other patient other than the Merck PAP patient for whom it was intended.
- Neither I nor my Practice will receive any reimbursement from Merck, whether for administrative 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 Programs only for use in an aggregated, de-identified format.
- I and my Practice grant the Programs the right to conduct periodic audits of my Practice's records to verify the information provided herein.
- I consent to receive communications related to the Programs by telephone, email, and/or fax.
- I understand that the Programs reserve 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.

Does the Facility use a Third-Party Administrator (TPA) to administer and manage its patient assistance programs? ☐ Yes ☐ No

By signing, I certify that I have read and agree to the above Healthcare Provider Certification and Attestation (if applicable based on the support my patient requested). By signing, I also certify that all information that I have provided in this enrollment form is complete and accurate.

HEALTHCARE PROVIDER SIGNATURE

Healthcare provider signature: _____ Date: _____

Healthcare provider name (please print): _____

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

To report a suspected adverse event involving a specific Merck product, please contact the Merck National Service Center at 800-444-2080.

MERCK