The Merck Access Program
PATIENT CONSENT FORM

WINREVAIR™ (sotatercept-csrk) for injection 45 mg, 60 mg

Phone: 888-637-2502, Fax: 877-219-7579 • The Merck Access Program, PO Box 592188, Orlando, FL 32859

INSTRUCTIONS

Step 1: Please complete the Patient Information section, review the Program Enrollment & Consent to Process Health Information, and check the box to give your consent. Review the Patient Authorization for Disclosure of Health Information section and sign and date the Form to complete your enrollment into The Merck Access Program (MAP). If you'd like to receive enrollment updates via text, please indicate your mobile number and check the box.

Step 2: If you'd like to be referred to the Merck Patient Assistance Program (PAP), review the Merck PAP Terms and Conditions beginning on page 4 and complete the required fields. Be sure to submit the requested documentation if you choose option 1, or sign and date this section if you choose option 2. Please also review the Income Verification requirements.

Once all required fields are completed and the Form has been signed and dated, fax the document to 877-219-7579.

PATIENT INFORMATION

***Required Field**

Patient is a US Resident*: ◯ Yes ◯ No Sex*: ◯ M ◯ F

Patient Name*: _____ Date of Birth*: _____

Address*: _____ City/State/Zip*: _____
(Street Address Only, No PO Boxes)

Phone (Home)*: _____ (Mobile): _____

Email: _____ Best time to contact: _____

Preferred Language: ◯ English ◯ Spanish ◯ Other: _____ Preferred Communication Method: ◯ Phone ◯ Email ◯ Mail

Healthcare Provider Name*: _____ Phone Number*: _____

Address: _____

PROGRAM ENROLLMENT & CONSENT TO PROCESS HEALTH INFORMATION

The Merck Access Program may provide information and support related to your insurance benefits for WINREVAIR™ (sotatercept-csrk), estimated out-of-pocket costs, and co-pay assistance options for which you may be eligible. The Merck Access Program will use your data only for the purposes listed below. Patient or Legal Representative signature is required for participation in The Merck Access Program.

If I am eligible to participate, then by consenting below, I agree to enroll in The Merck Access Program, sponsored by Merck Sharp & Dohme LLC. By choosing to enroll, I agree that The Merck Access Program and the Merck Patient Assistance Program (the "Programs"), Merck Sharp & Dohme LLC, and each of their employees, affiliates, representatives, agents, contractors, and data processors, including the administrators of the Programs (collectively, "Merck"), may collect, use, and disclose health information about me, including the details I provided on this form, information about my participation in the Programs, and other health information about me, such as my diagnosis and medication, to facilitate my participation in the Programs, including, as applicable, to: (i) verify my eligibility to enroll in the Programs and enroll me in the Programs for which I am eligible; (ii) coordinate my benefits and access to my Merck medication, provide reimbursement support, and administer the Programs; (iii) ensure compliance with laws and the rules of the Programs; and (iv) facilitate related internal business purposes, such as to provide customer support and evaluate and improve the Programs. I also agree that Merck may contact me via telephone, email, or mail using the contact information I provided on this form for purposes related to the Programs.

I understand that I am not required to consent to this processing of my health information. However, if I do not consent, I will not be able to participate in the Programs, as the processing of my health information is necessary for Merck to facilitate my participation in the Programs.

If I consent, I have the right to withdraw my consent at any time by calling 888-637-2502, by mailing The Merck Access Program, PO Box 592188, Orlando, FL 32859, or via web at WINREVAIRPatientAccess.iAssist.com. For more information about Merck's privacy practices and for privacy disclosures applicable to residents of certain US states, see our US Supplemental Privacy Notice at msdprivacy.com/us/en/supp-notice/ and our Consumer Health Data Privacy Policy at msdprivacy.com/us/en/chd-policy/.

◯ **I CONSENT** to the terms above and agree to enroll into The Merck Access Program.

◯ **I DO NOT CONSENT** to the terms above.

Patient Name*: _____ **Date of Birth*:** _____

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

By signing below, I authorize each of my physicians, pharmacies, and health plans to obtain, use, and disclose my protected health information, including the details I provided on this form, information about my participation in The Merck Access Program, the Merck Patient Assistance Program, and the WINREVAIR™ (sotatercept-csrk) Patient Support Program (collectively, the "Programs"), and other health information about me, such as my diagnosis, symptoms, medication, and inferences derived from the same (collectively, "PHI"), to The Merck Access Program, the Merck Patient Assistance Program, Merck Sharp & Dohme LLC, and each of their employees, affiliates, representatives, agents, contractors, and data processors, including the administrators of the Programs (collectively, "Merck"), to facilitate my participation in the Programs, including for the itemized purposes listed below. I also agree that Merck may obtain, use, and disclose my PHI to my physicians, pharmacies, and health plans, to my Legal Representative (if any), as well as to Merck vendors and third parties as appropriate to facilitate my participation in the Programs, including, as applicable, to: (i) verify my eligibility to enroll in the Programs and enroll me in the Programs for which I am eligible; (ii) coordinate my benefits and access to my Merck medication, provide reimbursement support, and administer the Programs; (iii) ensure compliance with laws and the rules of the Programs; and (iv) facilitate related internal business purposes, such as to provide customer support and evaluate and improve the Programs.

By signing this authorization, I also acknowledge my understanding that:

- The PHI disclosed pursuant to this authorization, once disclosed, may no longer be governed by certain federal or state privacy laws and may be subject to re-disclosure. However, I also understand that unless I separately consent to additional uses/disclosures, Merck intends to use and disclose my PHI only for the purposes described in this authorization.
- My specialty pharmacies may receive compensation in connection with disclosure of my PHI to Merck as described in this authorization.
- If I choose not to provide this authorization, that decision will not affect my eligibility for, or receipt of, treatment, including Merck products, or healthcare insurance benefits. However, I understand that I will not be able to receive any assistance from the Programs for which I may be eligible.
- I may cancel this authorization at any time by calling 888-637-2502, mailing a written request to The Merck Access Program, PO Box 592188, Orlando, FL 32859, or via web at WINREVAIRPatientAccess.iAssist.com. I understand that canceling my authorization will mean that my physicians, pharmacies, and health plans, as well as Merck, may no longer rely on this authorization to disclose my PHI, but that any use or disclosure of such information that occurs before my cancellation is received will be unaffected by my cancellation.
- If I do not cancel this authorization, the authorization will expire 5 years from the date of signature (or the maximum period allowed by applicable state law, if less than 5 years). The administrators of the Programs will retain the information they have collected about me in accordance with Merck's records retention policy.

Continued on Next Page

Patient Name*: _____ **Date of Birth*:** _____

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION (CONTINUED)

- I understand that I am entitled to a copy of my signed authorization and that I can obtain copies by downloading them after submission online or by calling 888-637-2502.

By signing, I certify that I have read and agree to the above Patient Authorization for Disclosure of Health Information.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: _____ **Date*:** _____

A Legal Representative is a person who has legal authority under applicable state law to bind you (the Patient) by signing each authorization or declaration in the Enrollment Form.

Name of Signing Party (Please Print): _____

DECLARATION OF LEGAL REPRESENTATIVE

◯ I declare that I am the Legal Representative of the Patient and that I have the legal authority under applicable state law to bind the Patient by signing each authorization or declaration in this Enrollment Form.

Phone Number of Legal Representative: _____ **Relationship of Legal Representative to the Patient:** _____

OPTIONAL ENROLLMENT IN WINREVAIR™ (sotatercept-csrk) PATIENT SUPPORT PROGRAM

If I am eligible to participate, then by consenting below, I also request to be enrolled into the WINREVAIR Patient Support Program that will provide me educational resources, product information, and other communications specific to WINREVAIR.

By choosing to enroll, I agree that Merck Sharp & Dohme LLC, and each of its employees, affiliates, representatives, agents, contractors, and data processors, including the administrators of the WINREVAIR Patient Support Program (collectively, "Merck"), may collect, use, and disclose health information about me, including the details I provided on this form, information about my participation in the Programs, and other health information about me, such as my diagnosis, symptoms, medication, and inferences derived from the same, to facilitate my participation in the WINREVAIR Patient Support Program, and specifically, to: (i) verify my eligibility to enroll in the WINREVAIR Patient Support Program and enroll me, if eligible; (ii) send me information, resources, and communications about WINREVAIR that are part of the WINREVAIR Patient Support Program; and (iii) facilitate related internal business purposes for the WINREVAIR Patient Support Program, such as to provide customer support and evaluate and improve the program.

I understand that I am not required to consent to this processing of my health information. However, if I do not consent, I will not be able to participate in the WINREVAIR Patient Support Program, as the processing of my health information is necessary for Merck to facilitate my participation in the WINREVAIR Patient Support Program. My decision to enroll or not enroll in the WINREVAIR Patient Support Program will not impact my eligibility for The Merck Access Program, Merck Patient Assistance Program, or receipt of treatment, including Merck products, or healthcare insurance benefits.

If I consent, I have the right to withdraw my consent at any time by calling 888-637-2502, by mailing The Merck Access Program, PO Box 592188, Orlando, FL 32859, or via web at WINREVAIRPatientAccess.iAssist.com. For more info about Merck's privacy practices and for privacy disclosures applicable to residents of certain US states, see our US Supplemental Privacy Notice at msdprivacy.com/us/en/supp-notice/ and our Consumer Health Data Privacy Policy at msdprivacy.com/us/en/chd-policy/.

◯ **I CONSENT** to the collection of my health information per the terms above.

◯ **I CONSENT** to the sharing and disclosure of my health information as identified above.

◯ **I DO NOT CONSENT** to the terms above.

**Please note: You must check both boxes starting with "I Consent" above to enroll in the WINREVAIR Patient Support Program. Participation is voluntary, and if you do not wish to enroll, please check "I DO NOT CONSENT to the terms above."*

OPTIONAL MOBILE AUTHORIZATION

I agree that The Merck Access Program, the Merck Patient Assistance Program, the WINREVAIR Patient Support Program (collectively, the "Programs"), Merck Sharp & Dohme LLC, and each of their employees, affiliates, representatives, agents, contractors, and data processors, including the administrators of the Programs (collectively, "Merck"), to the extent I voluntarily enroll in the Programs by Merck, may send me communications about resources and services related to my enrollment in the Programs via telephone call and text message. The number and type of calls and text messages will be based upon my program selections, and message and data rates may apply. At any time, I may request to stop telephone calls or text messages by following the opt-out directions provided during those communications. I UNDERSTAND THAT THESE COMMUNICATIONS MAY USE PRERECORDED/ARTIFICIAL VOICE MESSAGES AND/OR AN AUTOMATED SYSTEM AND THAT I DO NOT NEED TO AGREE TO RECEIVE CALLS/TEXT MESSAGES AS A CONDITION OF PURCHASING OR RECEIVING ANY PRODUCTS OR SERVICES FROM MERCK.

◯ **I CONSENT** to the terms above. Please list your mobile phone number: _____

◯ **I DO NOT CONSENT** to the terms above.

Patient Name*: _____ **Date of Birth*:** _____

OPTIONAL MARKETING AND BUSINESS CONSENT FOR COLLECTION OF HEALTH INFORMATION (EXCEPT MD RESIDENTS)

If I consent below, I agree that The Merck Access Program and Merck Sharp & Dohme LLC, and each of their employees, affiliates, representatives, agents, contractors, and data processors, including the administrators of The Merck Access Program (collectively, "Merck"), may (1) collect and process; and (2) if I also agree, share and disclose, health information about me, including the details I provided on this form, information about my participation in The Merck Access Program, and other health information, such as:

- Individual health conditions, treatment, diseases, or diagnosis;
- Use or purchase of prescribed medication;
- Diagnoses or diagnostic testing, treatment, or medication;
- Data that identifies a consumer seeking healthcare services;
- Inferences regarding a consumer's health derived from non-health information.

(collectively, "Health Information") for marketing purposes related to other Merck products and services, as well as for market research and related business purposes not necessary for my enrollment in The Merck Access Program.

I understand that I am not required to consent, and that I can participate in The Merck Access Program even if I do not consent to collection of my health information for such purposes.

If I consent, I have the right to withdraw my consent at any time by calling 888-637-2502 or via web at WINREVAIRPatientAccess.iAssist.com.

◯ **I CONSENT** to the optional collection of my health information per the terms above.

◯ **I CONSENT** to the optional sharing and disclosure of my health information as identified above by The Merck Access Program, sponsored by Merck Sharp & Dohme LLC.

◯ **I DO NOT CONSENT** to the terms above.

**Please note: You must check both boxes starting with "I Consent" above to opt-in to marketing and other business use of health information. Participation is voluntary, and if you do not wish to enroll, please check "I DO NOT CONSENT to the terms above."*

THE MERCK PATIENT ASSISTANCE PROGRAM (MERCK PAP) TERMS AND CONDITIONS
(PROVIDED THROUGH THE MERCK PATIENT ASSISTANCE PROGRAM, INC.)

By completing the information and signing below, the Patient is requesting to be referred to the Merck PAP for an eligibility determination.

To be eligible for enrollment in the Merck PAP for the Program Product, the Patient must request referral to the Merck PAP and meet the following Merck PAP eligibility requirements, as determined by the Merck PAP:

- The Patient is a US resident and has a prescription for the Program Product from a doctor or prescriber licensed in the US.
- The Patient does not have insurance or other coverage for the Program Product.
- The Patient meets certain financial eligibility criteria.

If the Patient is accepted into the Merck PAP, the following Terms and Conditions apply:

- Assistance will terminate if the Merck PAP becomes aware of any fraud or if the Program Product is no longer prescribed for the Patient.
- Completing this Form does not guarantee that the Patient will qualify for Patient assistance.
- The Patient will not seek reimbursement or credit for this prescription from any insurer, health plan, or government program. If the Patient is a member of a Medicare Part D plan, the Patient will not seek to have the prescription or any cost associated with it counted as part of the Patient's out-of-pocket cost for prescription drugs.
- The Patient does not have an insurance plan or employer that participates in or is involved in any way with an alternative funding program that requires or encourages the Patient to apply to the Merck Patient Assistance Program as a condition, requirement, or prerequisite for coverage of specific Merck medications.
- Merck PAP reserves the right to modify or discontinue this program, or terminate assistance at any time and without notice.
- The Patient authorizes Merck PAP and its affiliates to forward the prescription to a dispensing pharmacy on the Patient's behalf. Merck PAP is not acting as a dispensing pharmacy. Merck PAP is not responsible for verifying any information contained in the prescription forwarded as part of the enrollment process, including, without limitation, allergies, medical conditions, or other medications being taken by the Patient.
- The Patient will notify the Merck PAP immediately if anything changes with the Patient's prescription, income, or insurance coverage.
- The Merck PAP reserves the right to request documentation to verify the information provided in this Enrollment Form for purposes of determining the Patient's eligibility for assistance, and to conduct periodic audits of the Patient's enrollment, including the physician who will be supervising treatment, to verify the information provided herein.
- Assistance received through the Merck Patient Assistance Program is not insurance.

Patient Name*: _____ **Date of Birth*:** _____

MERCK PAP FINANCIAL HARDSHIP EXCEPTION

◯ The Patient requests consideration for Merck PAP Financial Hardship Exception

If the Patient does not meet the prescription drug coverage criteria, the Patient may still request assistance if experiencing a financial hardship (ie, cannot afford the deductible, co-pay, co-insurance, or other cost-sharing requirement of their insurance plan). The Patient eligibility request and enrollment under the financial hardship exception is subject to the following terms and conditions:

- The decision of whether the Patient is approved for a financial hardship exception resides exclusively with the Merck PAP.
- If the Patient has Medicare coverage, eligibility will automatically expire on December 31 of the current calendar year and the Patient must submit a new enrollment form before December 31 for eligibility determination for the following year. If the Patient fails to re-enroll before December 31, the Patient will no longer receive their medication from the Merck PAP.
- If the Patient has private prescription drug coverage, eligibility will automatically expire one (1) year from date of enrollment and the Patient must re-enroll for eligibility determination for the following year.

By signing, I certify that I have read and agree to the above Terms and Conditions of the Merck PAP and the Merck PAP Financial Hardship Exception, as applicable, based on the support I have requested. By signing, I also certify that all information I have provided in this application is complete and accurate.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: _____ **Date*:** _____

Name of Signing Party (Please Print): _____

Relationship to the Patient (If Other Than the Patient Signing): _____

MERCK PAP: INCOME VERIFICATION

HOUSEHOLD INCOME INFORMATION MUST BE PROVIDED FOR ENROLLMENT IN MERCK PAP

Current annual gross household income*: $_____

Number of household members (including the Patient): _____

*Total gross income before taxes, received within a 12-month period by all members of a household age 15 and older. (Please include before-tax wages, pension, interest/dividends, Social Security benefits, and any other sources of income.)

The Patient must authorize Merck PAP to verify their current gross annual household income (household income before taxes are withdrawn) by either:

◯ OPTION 1: Sending with this application, a COPY of only **ONE** of the following documents showing proof of the household income the Patient provided on the application form:

- Most recent 1040 Federal Tax Form
- One month of pay stubs, prior to the application date
- Social Security Benefits Letter
- Veteran Benefits Statement
- Unemployment Benefits Statement
- Disability Statement
- Pension Letter
- Letter from an employer

OR

◯ OPTION 2: Sign and date below authorizing the Merck PAP and other individuals involved in administering the Merck PAP to obtain his/her consumer report and/or other information related to his/her credit report to determine the Patient's eligibility to participate in the program. This verification will not affect the Patient's credit rating.

If selecting Option 1, include a COPY of only **ONE** of these documents with your completed, signed, and dated Enrollment Form. Please do not send an original document.

I understand the Merck Patient Assistance Program, Inc. (Merck PAP) will verify information about my current gross annual household income in order to ensure I am qualified for this program.

Patient should only sign this section if they are NOT providing one of the proof of income documents.

By signing below, I am providing written authorization to Merck PAP and other individuals involved in administering the Merck PAP to obtain my consumer report and/or other information related to my credit report to determine my eligibility to participate in the program. This verification will not affect my credit rating.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: _____ **Date*:** _____

Name of Signing Party (Please Print): _____

Relationship to the Patient (If Other Than the Patient Signing): _____

If you have questions about completing this form or need additional information, please call **888-637-2502.**

MERCK