MerckHelps™

MERCK BULK REPLACEMENT PROGRAM

How Can I Submit My Completed Application?

FAX 1-215-616-2032

How Can We Help?

For inquiries, please call 1-888-727-8180

PROGRAM INFORMATION

The Merck Patient Assistance Program may be able to provide Merck medicines and adult vaccines free of charge through periodic bulk replenishments to eligible facilities that serve a large percentage of low-income, uninsured patients. Types of eligible facilities include outpatient pharmacies of disproportionate share hospitals, non-profit healthcare clinics, and community health facilities that have a licensed outpatient central fill pharmacy that is owned and operated by the facility.

Facilities participating in the program are responsible for confirming patient eligibility according to established financial and insurance criteria prior to dispensing product. Replenishment is limited to products administered or dispensed to eligible uninsured and low-income patients.

To participate, facilities must be a non-profit or 340B entity and maintain a licensed outpatient pharmacy or dispensary under facility ownership and operation. Facilities must also maintain documented standard operating procedures that align with program requirements, including patient eligibility review and prevention of third-party billing for program products.

SECTION 1: FACILITY INFORMATION

Facility name*

Address*

Address line 2

City*

State/Territory*

ZIP code*

Phone number*

Fax

Which best describes the facility?* ☐ Free clinic ☐ Non-profit charitable pharmacy ☐ Community health center ☐ Facility owned central fill pharmacy ☐ Disproportionate share hospital ☐ Federally qualified health center ☐ Other (i.e. stand-alone pharmacy)

Is the facility above a single location or a network of facilities?* ☐ Single location ☐ Network of facilities

If network of facilities, list all locations*

Non-profit status:* ☐ 501(c)(3) ☐ Other

If other, non-profit status*

340B ID #

DSH % if available

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PLEASE FILL OUT ALL REQUIRED FIELDS, WHICH ARE INDICATED WITH AN ASTERISK *

SECTION 1: FACILITY INFORMATION (CONT.)

Pharmacy type:* ☐ Onsite outpatient pharmacy ☐ Onsite outpatient dispensary ☐ Other _____ If other, explain pharmacy type*

_____ Pharmacy license #*

_____ Pharmacy license expiration date*

_____ Pharmacist in Charge (PIC) license #

_____ PIC license expiration date

_____ Medical provider #

_____ Days and hours of pharmacy operation*

_____ Estimated total number of outpatients served monthly*

_____ Estimated number of uninsured, indigent outpatients (volume and percentage) per month/year*

_____ Patient income requirement to qualify for free medications*

Does your facility participate in other manufacturer bulk replacement programs?* ☐ Yes _____ If yes, how many?* ☐ No

Does your facility utilize a third party administrator (TPA)?* ☐ Yes _____ If yes, name of TPA* ☐ No

SECTION 2: STANDARD OPERATING PROCEDURES RECOMMENDED

Please check the SOPs your facility is currently utilizing.

Patient eligibility:

☐ Eligibility policies and procedures (including criteria and determination of eligibility, proof requirements)

☐ Insurance verification and documentation process

☐ Reenrollment (to occur annually at the very least)

☐ Patient enrollment forms (enrollment/ reenrollment packet)

☐ Record retention policy

☐ Staff training

Pharmacy:

☐ Distribution of product to patients

☐ Product replenishment

☐ Return to stock

☐ Return of damaged/expired medication

☐ Adverse events and product quality complaint reporting

☐ Shipment receipt and storage

☐ Record retention

☐ Billing codes

☐ Pharmacy security

Vaccines:

☐ Vaccine administration process (i.e. vaccine information sheet [VIS], consent form(s), flow sheets)

☐ Process for validating patient eligibility

☐ Disaster recovery

☐ Refrigerator/ freezer temperature monitor

☐ Picture of refrigerator/ freezer

☐ Locked refrigeration unit

SECTION 3: CONTACT INFORMATION

_____ Contact name*

_____ Phone number*

_____ Email*