Merck Care™
Hepatitis

ENROLMENT AND CONSENT FORM

merckcarehepC@innomar-strategies.com
T. 1-866-872-5773 • F. 1-866-949-9913

By signing below, I give my consent to my healthcare provider (i.e. doctor, nurse) and my health insurer to provide details of my personal information (which may include: my name, address and phone number, medical history, financial information and health insurance information) to the MERCK CARE™ Program, and those managing the program, as may be required for the purpose of determining my eligibility for participation in the services offered by the MERCK CARE™ Program. I understand that the MERCK CARE™ Program may, based on eligibility, provide any of the following types of assistance: financial, reimbursement, compassionate use and nursing support services. By signing below, I also allow my healthcare provider and those managing the MERCK CARE™ Program to exchange needed information about me and my medical conditions for the purposes of the program, and either one may contact me regarding any questions (including for example, questions about financial reimbursement for PEGETRON® (ribavirin plus peginterferon alfa-2b) or VICTRELIS™ (boceprevir). In carrying out these activities, there may also be an exchange of my information, as required for the management of my file in the MERCK CARE™ Program, with my health insurer, nurses, physicians and pharmacists. I understand that although the MERCK CARE™ Program is provided by Merck Canada Inc. for the purpose of assisting patients who have been prescribed PEGETRON® and/or VICTRELIS™, Merck Canada will not have access to my personal information that would allow Merck Canada to know who I am. My health information will not be used by the MERCK CARE™ Program for any other purpose. I may cancel this agreement at any time by mailing or faxing a signed request to my healthcare provider and health insurer(s), but if I do so, I will not be able to get help with reimbursement for PEGETRON®/VICTRELIS™ and any information already provided will be retained for purposes documenting the management of services provided to that point. **I understand my rights under this agreement and I am aware that I am entitled to a copy of this document**.

Patient Printed Name: ______________________ Patient Signature: ______________________ Date: ______________

PATIENT CONTACT INFORMATION (PLEASE PRINT)

Last Name		First Name	
Street Address	City	Province	Postal Code
Home Phone #	Work Phone #	Date of Birth	Sex / Language of Preference
Coverage Details			
Patient Pharmacy	Physician Name	Attending Nurse Practitioner Name	
Physician Address	City	Province	Postal Code
Physician Office Contact		Physician Contact Phone #	

PATIENT DISEASE AND TREATMENT STATUS to be completed by HealthCare Provider

GENOTYPE: _____ ☐ TREATMENT NAÏVE ☐ PRIOR RELAPSER ☐ PRIOR PARTIAL RESPONDER ☐ PRIOR NULL RESPONDER

HIV CO-INFECTED: ☐ YES ☐ NO CIRRHOTIC: ☐ YES ☐ NO TRANSPLANT: ☐ YES ☐ NO

LIVER FIBROSIS SCORE: ______________________ ANTICIPATED TREATMENT START DATE: ______________________

TO BE COMPLETED BY HEALTHCARE PROVIDER - the following reflects the information set out in the patient's prescription

THE FOLLOWING IS NOT A VALID PRESCRIPTION

INFORMATION ON PRESCRIPTION (PegIFNα2B = peginterferon alfa-2b RBV= ribavirin BOC= boceprevir)

☐ PEGETRON® 2 X 80 mcg PegIFNα2b pens (0.5 mL) + 56 X 200 mg RBV caps

☐ PEGETRON® 2 X 100 mcg PegIFNα2b pens (0.5 mL) + 56 X 200 mg RBV caps

☐ PEGETRON® 2 X 120 mcg PegIFNα2b pens (0.5 mL) + 70 X 200 mg RBV caps

☐ PEGETRON® 2 X 150 mcg PegIFNα2b pens (0.5 mL) + 84 X 200 mg RBV caps

☐ PEGETRON® 2 X 150 mcg PegIFNα2b pens (0.5 mL) + 98 X 200 mg RBV caps

☐ VICTRELIS TRIPLE™ 2 X 80 mcg PegIFNα2b pens (0.5 mL) + 56 X 200 mg RBV caps + 168 X 200 mg BOC caps

☐ VICTRELIS TRIPLE™ 2 X 100 mcg PegIFNα2b pens (0.5 mL) + 56 X 200 mg RBV caps + 168 X 200 mg BOC caps

☐ VICTRELIS TRIPLE™ 2 X 120 mcg PegIFNα2b pens (0.5 mL) + 70 X 200 mg RBV caps + 168 X 200 mg BOC caps

☐ VICTRELIS TRIPLE™ 2 X 150 mcg PegIFNα2b pens (0.5 mL) + 84 X 200 mg RBV caps + 168 X 200 mg BOC caps

☐ VICTRELIS TRIPLE™ 2 X 150 mcg PegIFNα2b pens (0.5 mL) + 98 X 200 mg RBV caps + 168 X 200 mg BOC caps

☐ VICTRELIS™ 168 X 200 mg BOC caps

I confirm that the above reflects the medication and prescription provided to the patient by the patient's prescribing physician indicated above.

Signature of HealthCare Provider: ______________________ Printed Name & Title: ______________________ Date: ______________

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