PATIENT INFORMATION SECTION

PATIENT AUTHORIZATION *(continued)*

and any prescription for NEXPLANON® (etonogestrel implant) (my "PHI"). I authorize my physician, pharmacy(ies), and my health plan(s) to disclose my PHI to Lash as necessary to complete the insurance investigation process. I further authorize Lash and the Specialty Pharmacies (Accredo Pharmacy, AllianceRx Walgreens Prime, ASPN Pharmacies, LLC, CVS Health Pharmacy, Humana Specialty Pharmacy, or Magellan Rx Pharmacy) and their respective affiliates to exchange my PHI to provide support and to disclose the information to my health plan(s) and their contractors for the purpose of coordination of benefits, reimbursement support, investigating insurance coverage and coordination of the delivery, receipt and storage of my prescription medication for NEXPLANON for the sole purpose of administration to me by my prescribing provider named above.

I authorize the Specialty Pharmacy to use my PHI to contact me via mail, telephone, text, or email in connection with information related to this Enrollment Form. In order for the Specialty Pharmacy to ship my prescription medication for NEXPLANON directly to my prescribing provider, I authorize the Specialty Pharmacy to communicate with my prescribing provider about my PHI in order to coordinate the delivery, receipt, and storage of my prescription medication for NEXPLANON for the sole purpose of administration of my prescribing provider at my next scheduled appointment. I understand that my PHI disclosed pursuant to this Authorization may no longer be protected by certain federal privacy laws and may be re-disclosed by the recipient, but that Lash has agreed to use my PHI only for the purposes described herein.

I understand that if I do not sign this Authorization, that will not affect my receipt of treatment (including with NEXPLANON) or of health insurance benefits, but that I will not be able to obtain certain assistance provided by Lash on behalf of Merck. I understand that I may cancel this Authorization at any time by mailing a written request for such cancellation to Lash, PO Box 741, Monroeville, PA, 15146-0741. I understand that canceling my Authorization will not affect uses and disclosures of PHI already made in reliance on the Authorization before my cancellation is received by Lash.

If I do not cancel this Authorization, the Authorization will expire 15 months from the date of signature (or the maximum period allowed by applicable state law, if less than 15 months). Merck has retained Lash and the Specialty Pharmacies to provide support to customers, including reimbursement support. Information and questions related to the information provided in regard to this request should be referred directly to Lash. Merck personnel are not aware of patient-specific reimbursement information and are not permitted to discuss such information with customers. I have read this document or have had it explained to me. I understand that I may request a copy of this Authorization once it has been signed.

Patient Signature:______________________________ **Date:**__________

Print Name:______________________________ **Date:**__________

Relationship to patient if signing on their behalf:______________ **Date:**__________

If you have questions about completing this form or need additional information, please call 844-NEX-4321 (844-639-4321). Thank you.