<table>
<thead>
<tr>
<th><strong>Asmanex Twistanler®</strong></th>
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<tbody>
<tr>
<td><strong>Medication name</strong></td>
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<tr>
<td><strong>Medication classification</strong></td>
</tr>
<tr>
<td><strong>Prescription assistance program</strong></td>
</tr>
</tbody>
</table>
| **Contact information and website** | Phone: (800) 727-5400  
| | Hours: Monday-Friday 8 a.m. - 8 p.m. EST  
| | Mailing address:  
| | Merck Patient Assistance Program  
| | P.O. Box 690  
| | Horsham, PA 19044-9979  
| | [http://www.merckhelps.com/ASMANEX%20%20TWISTHALE R](http://www.merckhelps.com/ASMANEX%20%20TWISTHALE R) |
| **Eligibility criteria** |  
| | • U.S. resident  
| | • Prescription from a health care provider licensed in the U.S.  
| | • No insurance or other drug coverage  
| | • Low annual income at or below:  
| | o $49,960 for a household of one  
| | o $67,640 for couples  
| | o $103,000 for a family of four or less  
| | • Patient eligibility is determined on a case-by-case basis, and based on economic and insurance criteria  
| | • You can request that an exception be made for you |
| **Cost and enrollment** |  
| | • A single application may include prescriptions for up to 3 Merck medicines  
| | • Click on the link provided above and click on the “How to Get Started” tab  
| | • The enrollment form is located on the side bar (available in English and Spanish)  
| | • Follow the instructions and complete all required sections on the enrollment form  
| | • Take completed application to your physician/prescriber to be signed and have them write your prescription(s) in section two of the application  
| | • Mail completed applications to:  
| | Merck Patient Assistance Program  
| | P.O. Box 690  
| | Horsham, PA 19044-9979  
| | • Receive up to 90-day supply of medication mailed to healthcare provider’s office or the patient’s home address (section three)  
<p>| | • Enrollment may be limited to one calendar year, patients may reapply |</p>
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| **Contact information and website** | Phone: (877) 296-4673  
Fax: (877) 298-1012  
Mailing address: Prescription Hope, Inc.  
P.O.Box 2700  
Westerville, Ohio 43086  
https://manage.prescriptionhope.com/enrollment/register.php |
| **Eligibility criteria** | • US resident  
• May be uninsured  
• Restrictions do apply (must complete enrollment application)  
• The average income to qualify for the Prescription Hope pharmacy program:  
  o Individuals earning around $30,000 per year  
  o Couples earning around $50,000 per year  
  o Guidelines increase with each additional member in households earning up to $100,000 per year |
| **Cost and enrollment** | • $50 per month, per medication  
• Use link provided and choose to “Enroll online” or “Printable form”  
• Complete all required sections of the Prescription Hope enrollment form  
• Need to include the following documents if applicable:  
  o If you are on Medicare, you must submit a *copy* of your most recent Social Security New Benefit Amount Statement  
  o If you applied for Medicaid or have applied for low-income subsidy (LIS), you must submit a *copy* of the determination letter  
• Completed and signed application with required documents may be completed online, faxed or mailed to:  
  o Prescription Hope, Inc.  
P.O. Box 2700  
Westerville, Ohio 43086  
Fax: (877) 298-1012  
• Prescription Hope does not guarantee your approval for patient assistance programs; it is up to each
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<td>• After enrollment, you can typically expect to receive 90 days’ worth of medication delivered to your home or doctor’s office within 4 to 6 weeks</td>
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<td>• Refills will be delivered automatically before your current supply runs out</td>
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<td>• If Prescription Hope cannot help you with a medication, there will never be a fee for that medication</td>
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