The Organon Access Program
ENROLLMENT FORM

01/2025

Ontruzant®
trastuzumab-dttb
for injection, for intravenous use 21 mg/mL

Before prescribing ONTRUZANT, please read the accompanying Prescribing Information, including the Boxed Warning.

Phone: 844-326-2986, Fax: 800-538-5812 • The Organon Access Program, PO Box 2889, Columbus, OH 43216

TO GET STARTED, COMPLETE THE ENROLLMENT FORM AND SUBMIT ONLINE, OR PRINT AND FAX THE COMPLETED DOWNLOADABLE FORM TO 800-538-5812. IF REQUESTING A REFERRAL TO THE ORGANON PATIENT ASSISTANCE PROGRAM, PLEASE INCLUDE A PRESCRIPTION FOR ONTRUZANT.

PLEASE CHECK ALL BOXES THAT APPLY AND COMPLETE THE APPROPRIATE SECTION(S) OF THE FORM

Check off the relevant box(es).

- ☐ Patient Benefits Investigation only
- ☐ Patient Benefits Investigation and/or information about the Prior Authorization or Appeals Process
- ☐ Organon Co-pay Assistance Program only
  (Select this box to proceed with reviewing your patient's eligibility for the Organon Co-pay Assistance Program only. Please note, your office will not receive patient Benefits Investigation details and/or information about the Prior Authorization or Appeals Process.)
- ☐ Organon Co-pay Assistance Program
  (By selecting this box, your office will receive patient Benefits Investigation details and/or information about the Prior Authorization or Appeals Process.)
- ☐ Referral to the Organon Patient Assistance Program for eligibility determination
  (sponsored by the Organon Patient Assistance Program Inc.)

Please be sure to send a prescription for ONTRUZANT.

Patients only need to sign page 3 if they would like Co-pay Assistance Program or Patient Assistance Program support.
HCPs need to sign page 4 for all support options. If referring patient to the Patient Assistance Program, please include a prescription for ONTRUZANT.

PATIENT INFORMATION SECTION

PATIENT INFORMATION

Fill out patient information completely.

*Required fields are marked with an asterisk (*)

Patient is a US resident*: ☐ Yes ☐ No

Check off any box applicable to the patient.

Patient name*:_____ Date of birth*:_____ Sex: M ☐ F ☐

Address*:_____ City/state/zip*:_____
(Street address only, no PO boxes)

Phone*:_____

While a mobile phone number is preferred, any telephone number will be accepted.

Email:_____

INSURANCE INFORMATION

Complete the information for the patient's insurance and supplementary insurance (if applicable). Include a copy of the front and back of any insurance card(s).

PLEASE COMPLETE ALL THAT APPLY AND **INCLUDE A FRONT AND BACK COPY OF INSURANCE CARD** FOR EACH TYPE OF INSURANCE

☐ **Patient Has No Insurance** **Patient Has Insurance Through Medicare*:** ☐ Yes ☐ No (If Yes) ☐ Part A ☐ Part B ☐ Part D ☐ Medicare Advantage

If the patient has insurance through Medicare, check off the appropriate Medicare plan(s).

Primary insurer (including Medicaid, Medicare, veterans benefits, and private insurers)

Plan name and state*:_____

Please be sure that the plan name and policy ID number match what is on the patient's ID card.

Phone number for customer service*:_____ Name of policyholder*:_____

Policyholder date of birth:_____ Policyholder relation to patient:_____

Group no.:_____ Policy ID no*:_____

Secondary/supplemental insurer

Plan name and state:_____

Phone number for customer service:_____ Name of policyholder:_____

Policyholder date of birth:_____ Policyholder relation to patient:_____

Group no.:_____ Policy ID no.:_____

REQUIRED FOR THE ORGANON PATIENT ASSISTANCE PROGRAM

Complete this section for patients applying for the Organon Patient Assistance Program.

Current annual gross household income (parent/guardian if patient is under age 18): $_____

Number of household members (including patient): _____
(Please include: before-tax wages, pension, interest/dividends, Social Security benefits, and any other sources of income.)

Patient name:_____

Write the patient's name on each page of the enrollment form.

PATIENT INFORMATION SECTION

PATIENT AUTHORIZATION

I understand that before I may have communications with The Organon Access Program, sponsored by Organon LLC, a subsidiary of Organon & Co. ("Organon"), or receive assistance from the Organon Patient Assistance Program ("Organon PAP"), sponsored by the Organon Patient Assistance Program Inc. (individually, "a Program"; collectively, "the Programs"), the administrators of the Programs, its affiliates, contractors and other third parties providing services related to these programs (collectively, "Program Administrators"), will need to obtain, review, use, and disclose my personal health information ("PHI"), including information relating to my medical condition and prescription medications and the information disclosed in this patient enrollment form.

I therefore authorize each of my physicians, pharmacies, and health plans to disclose my PHI, as necessary, to the Program Administrators so they may verify my eligibility to enroll in the Programs and enroll me in the Programs for which I am eligible; and to provide me with reimbursement support and to investigate my insurance coverage in connection with The Organon Access Program.

I also authorize the Program Administrators to (i) use my PHI to provide the services described in this enrollment form, including to communicate Program-related content by US postal mail, telephone, text, or email, and to prepare summaries that do not include my PHI for statistical purposes; and (ii) share my PHI to one another and with my physicians and pharmacists as well as to Medicare, my health plans, and their administrators, contractors, or representatives, in order for them to coordinate my benefits, to provide, when applicable, reimbursement support, and to investigate my insurance coverage.

I also authorize the Program Administrators to disclose my PHI to authorized representatives of Organon as necessary to ensure compliance with the rules of the Programs. I also authorize Organon's authorized representatives to use and disclose my PHI to communicate with the Program Administrators, my physicians, pharmacies, and me for compliance purposes.

If I have designated a Personal Representative, I authorize the Program Administrators to use and disclose my PHI in communicating with such Personal Representative for the purpose of verifying the information I have provided in this form and/or coordinating the provision of benefits that may be available to me under the Programs.

I understand that the PHI disclosed pursuant to this authorization, once disclosed, may not be governed by federal privacy law and may be subject to re-disclosure, but I also understand that the administrators of the Programs and their contractors and other representatives intend to use and disclose my PHI only for the purposes described in this authorization or as required by law. I further understand that if I choose not to provide this authorization, it will not affect my eligibility for, or receipt of, treatment, including Organon products, or health care insurance benefits, but I will not be able to receive any assistance from the Programs for which I may be eligible.

I understand that I may cancel this authorization at any time by telephoning The Organon Access Program at 844-326-2986 or by mailing a written request for cancellation to The Organon Access Program, PO Box 2889, Columbus, OH 43216.

I understand that canceling my authorization will mean that my physicians, pharmacies, and health plans, as well as the Programs and Program Administrators, may no longer rely on this authorization to use or 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.

I understand that if I do not cancel this authorization, the authorization will expire 3 years from the date of signature (or the maximum period allowed by applicable state law, if less than 3 years). The Program Administrators will retain the information I have submitted in accordance with Organon's records retention policy.

I understand that I am entitled to receive a copy of this authorization once it has been signed. I have read this authorization or have had it explained to me.

☐ I consent to receive marketing calls and texts from and on behalf of The Organon Access Program, made with an autodialed or prerecorded voice, at the cell phone number for me (the patient) provided on this form. I understand that I do not need to provide this consent in order to purchase any Organon products. I understand that text message and data rates may apply. Frequency may vary. Reply STOP to cancel, HELP for help.

View our privacy policy at https://www.organon.com/privacy/.

Check this box to consent to calls and texts from The Organon Access Program.

By signing, I certify that I have read and agree to the above Patient Authorization based on the support I have requested.

PATIENT SIGNATURE

Signature of patient, parent, legal guardian, or legal representative: _____ **Date:** _____

Name of signing party (please print): _____

Relationship to patient (if other than patient signing): _____

The patient or representative must sign here.

Date is required.

THE ORGANON CO-PAY ASSISTANCE PROGRAM TERMS AND CONDITIONS

To receive benefits under the Organon Co-pay Assistance Program ("Co-pay Assistance Program") for ONTRUZANT® (trastuzumab-dttb) for injection, for intravenous use 21 mg/mL ("Program Product"), the patient must enroll in the Co-pay Assistance Program and be accepted as eligible. Patient may contact The Organon Access Program for current Program Product(s) subject to these terms and conditions ("Terms and Conditions").

- Patient must be prescribed the Program Product for an FDA-approved indication.
- Patient must have private health insurance that provides coverage for the cost of the Program Product under a medical benefit plan.
- **The Co-pay Assistance Program is not valid for patients covered under Medicaid (including Medicaid patients enrolled in a qualified health plan purchased through a health insurance exchange [marketplace] established by a state government or the federal government), Medicare, a Medicare Part D or Medicare Advantage plan (regardless of whether a specific prescription is covered), TRICARE, CHAMPUS, Puerto Rico Government Health Insurance Plan ("Healthcare Reform"), or any other state or federal medical or pharmaceutical benefit program or pharmaceutical assistance program (collectively, "Government Programs"). The Co-pay Assistance Program is not valid for uninsured patients.**
- **Subject to changes in state law, the Co-pay Assistance Program may become invalid for residents of Massachusetts prior to its expiration date.**
- Patient must have an out-of-pocket cost for the Program Product and be administered the Program Product prior to the expiration date of the Co-pay Assistance Program. The benefit available under the Co-pay Assistance Program is valid for the patient's out-of-pocket cost for the Program Product only. **It is not valid for any other out-of-pocket costs** (for example, office visit charges or medication administration charges) even if such costs are associated with the administration of the Program Product. Claim for Program Product must be submitted by the health care provider to the patient's private health insurance separately from other services and products.
- **Patient must pay the first $5 of co-pay per administration of Program Product.** The benefit available under the Co-pay Assistance Program is limited to the amount the patient's private health insurance company indicates on the Explanation of Benefits ("EOB") that the patient is obligated to pay for the Program Product, less $5, up to an annual maximum. The maximum Co-pay Assistance Program benefit per patient, per calendar year (January 1 through December 31), is $25,000.
- An EOB from patient's private health insurance must be submitted within **180 days** of the date of the EOB for patient to receive co-pay assistance benefit, provided, however, that no EOB may be submitted more than **180 days** after the expiration date of Co-pay Assistance Program. The EOB must reflect the patient's out-of-pocket cost for the Program Product and submission of the claim by the patient's provider for the cost of the Program Product.
- Patient and provider agree not to seek reimbursement for all or any part of the benefit received by the patient through the Co-pay Assistance Program. Patient and provider are responsible for reporting receipt of Co-pay Assistance Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Co-pay Assistance Program, as may be required.
- Patient must be a resident of the United States or the Commonwealth of Puerto Rico. Product must originate and be administered to patient in the United States or the Commonwealth of Puerto Rico.
- The Co-pay Assistance Program may apply to patient out-of-pocket costs incurred for Program Product within 180 days prior to the date patient is enrolled in the Co-pay Assistance Program, subject to annual Co-pay Assistance Program maximum and the applicable Terms and Conditions based on Program Product administration date. Patient or health care provider may contact The Organon Access Program for more information.
- All information applicable to the Co-pay Assistance Program requested on this form must be provided, and all certifications must be signed. Forms that are modified or do not contain all the necessary information will not be eligible for benefits under the Co-pay Assistance Program.

Patient name:_____

Write the patient's name on each page of the enrollment form.

PATIENT INFORMATION SECTION

THE ORGANON CO-PAY ASSISTANCE PROGRAM TERMS AND CONDITIONS (*continued*)

- No other purchase is necessary.
- **The Co-pay Assistance Program is not insurance.**
- The Co-pay Assistance Program forms may not be sold, purchased, traded, or counterfeited. Void if reproduced.
- The Co-pay Assistance Program is void where prohibited by law, taxed, or restricted. The Co-pay Assistance Program is not transferable. No substitutions are permitted.
- The Co-pay Assistance Program benefit cannot be combined with any other co-pay assistance program, free trial, discount, prescription savings card, or other offer.
- If acquiring Program Product from a specialty pharmacy (to be later administered in a physician office or outpatient institution), additional documentation may be required.
- Organon reserves the right to rescind, revoke, or amend the Co-pay Assistance Program at any time without notice.
- Data related to patient's receipt of Co-pay Assistance Program benefits may be collected, analyzed, and shared with Organon, for market research and other purposes related to assessing Co-pay Assistance Programs. Data shared with Organon will be aggregated and de-identified, meaning it will be combined with data related to other co-pay assistance program redemptions and will not identify patient.
- **Before prescribing ONTRUZANT® (trastuzumab-dttb) for injection, for intravenous use 21 mg/mL, please read the accompanying Prescribing Information, including the Boxed Warning.**

PATIENT CERTIFICATION: THE ORGANON CO-PAY ASSISTANCE PROGRAM

I certify that I have read and understand the Terms and Conditions of the Co-pay Assistance Program. I certify that I meet the eligibility requirements listed in the Terms and Conditions and that the information I am providing on this form is true and correct.

I certify that I have private insurance and that no part of the costs associated with the Program Product for which I am seeking a benefit under the Co-pay Assistance Program was or will be covered or reimbursed by a Government Program, as that term is defined in the Co-pay Assistance Program Terms and Conditions.

I understand that if I begin to have coverage under any Government Program or if my state prohibits the redemption of manufacturer co-pay assistance (coupons) at any time, I will no longer be eligible to receive benefits under the Co-pay Assistance Program. If I am enrolled in a qualified health plan purchased through a health insurance exchange established by a state government or the federal government ("QHP"), I understand that if the federal government or my state government prohibits the redemption of manufacturer co-pay assistance (coupons) by enrollees in QHPs at any time, I will no longer be eligible to receive benefits under the Co-pay Assistance Program.

I certify that my insurance company has not prohibited the redemption of manufacturer co-pay assistance (coupons) for the Program Product and I understand that if at any time my insurance company prohibits the redemption of manufacturer co-pay assistance (coupons) for the Program Product, I will no longer be eligible to receive benefits under the Co-pay Assistance Program.

I understand that I am responsible for reporting receipt of Co-pay Assistance Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Co-pay Assistance Program, as may be required.

I agree not to seek reimbursement for all or any part of the benefit I receive through the Co-pay Assistance Program. I understand that my health care provider will submit a claim to my private insurance company for the Program Product administered to me. I authorize my health care provider to submit the Explanation of Benefits received from my private insurance company to the Co-pay Assistance Program and to receive, on my behalf, if applicable, any benefit for which I am eligible under the Program. I understand that my health care provider will apply any amounts received from the Co-pay Assistance Program toward the satisfaction of my obligation for the cost of the Program Product only. I understand that I am responsible to pay my health care provider the amount I owe per administration of Program Product consistent with the applicable Terms and Conditions of the Co-pay Assistance Program, and any balance owed to my health care provider not covered by the Co-pay Assistance Program.

I understand that any benefit I am eligible for under the Co-pay Assistance Program will be paid directly to my health care provider, on my behalf, if applicable, or directly to me. If I have already paid my health care provider for my share of the cost of the Program Product for which I later receive a benefit through the Co-pay Assistance Program, I will seek the amount, less the amount I owe per administration, if applicable in accordance with the Co-pay Assistance Program Terms and Conditions, back from my health care provider.

If acquiring Program Product from a specialty pharmacy (to be later administered in a physician office or outpatient institution), I understand that additional documentation may be required.

I understand that I am free to switch health care providers at any time without affecting my eligibility to receive benefits under the Co-pay Assistance Program, provided, however, that my new health care provider must complete the information required on the form, including the Health Care Provider and/or Specialty Pharmacist Certifications, as applicable, before any Co-pay Assistance Program benefit for which I am eligible may be paid, if applicable, to such health care provider on my behalf.

I will inform the Co-pay Assistance Program immediately in the event I become ineligible to receive benefits under the Terms and Conditions or if my insurance changes.

THE ORGANON PATIENT ASSISTANCE PROGRAM

I certify that all of the information provided in this application, including information about household income, is complete and accurate.

I understand that Organon PAP assistance will terminate if the Organon PAP becomes aware of any fraud or if this medication is no longer prescribed for me. I understand that completing this application does not ensure that I will qualify for patient assistance. I certify that I will not seek reimbursement or credit for this prescription from any insurer, health plan, or government program. If I am a member of a Medicare Part D plan, I will not seek to have the prescription or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs.

I understand that Organon PAP reserves the right to modify the application form, modify or discontinue this Program, or terminate assistance at any time and without notice. I authorize Organon PAP and its affiliates to forward the prescription to a dispensing pharmacy on my behalf. Organon PAP is not acting as a dispensing pharmacy. Organon 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 me.

I understand that I will notify the Organon PAP immediately if anything changes with my prescription, income, or my insurance coverage.

I understand that the Organon PAP reserves the right to request documentation to verify the information provided in this application for purposes of determining my eligibility for assistance, and to conduct periodic audits of my enrollment, including the health care provider who will be supervising my treatment, to verify the information provided herein.

I understand that assistance received through the Organon Patient Assistance Program is not insurance.

I understand that patients with commercial insurance are not eligible to enroll in Organon PAP.

I understand that if I have Medicare coverage, my eligibility may expire on December 31st of the current calendar year and the Organon PAP will conduct a benefit verification to confirm my eligibility and automatic enrollment for the following calendar year if I wish to continue participating in the Organon PAP.

PATIENT ACKNOWLEDGMENT AND SIGNATURE

Include a completed Representative's Form, if necessary.

If another person will be legally signing on behalf of the patient or if the patient would like to designate a person to act on their behalf to verify information and coordinate provisions of the programs described in this enrollment form, PLEASE INCLUDE A COMPLETED REPRESENTATIVE'S FORM WITH THIS ENROLLMENT FORM.

By signing, I certify that I have read and agree to the above Patient Certification and the Terms and Conditions of the Organon Co-pay Assistance Program and the Organon Patient Assistance Program based on the support I have requested. By signing, I also certify that all information that I have provided in this application is complete and accurate.

PATIENT SIGNATURE

The patient or representative is required to sign here.

Signature of patient, parent, legal guardian, or legal representative: _____ **Date:** _____

Name of signing party (please print): _____ **Relationship to patient (if other than patient signing):** _____

Date is required.

Patient name:_____

Write the patient's name on each page of the enrollment form.

HEALTH CARE PROVIDER INFORMATION SECTION

HEALTH CARE PROVIDER INFORMATION (to be completed by health care provider)

*Required fields are marked with an asterisk (*)

Health care provider name*:_____

Health care provider tax ID no.:_____

Health care provider NPI no.*:_____
(NPI must match the HCP signature on page 4)

Health care provider State license no.:_____

Health care provider State license expiration date:_____

Address*:_____
(Street address only, no PO boxes)

City/state/zip*:_____

Phone*:_____ Fax*:_____

Office contact person:_____

Office contact number:_____

Email:_____

Include the email address of the office contact person.

Practice/Facility name:_____

Practice tax ID no.:_____

Practice NPI no.:_____

Practice/Facility address:_____
(Street address only, no PO boxes)

City/state/zip:_____

Include the primary diagnosis code.

Please list primary diagnosis code*:

_____

Product use is consistent with labeled indications for ONTRUZANT® (trastuzumab-dttb) for injection, for intravenous use 21 mg/mL*: **Yes ☐ No ☐**

Next treatment date:

_____

Include the patient's next treatment date.

Confirm product use is consistent with labeled indications.

HEALTH CARE PROVIDER ATTESTATION

By signing below, I represent and warrant the following:

- This Enrollment Form has been prepared exclusively by the health care provider or health care provider's office identified in this Enrollment Form ("my Practice").
- By signing below, I represent and warrant that I am authorized pursuant to the laws of my state of licensure to prescribe ONTRUZANT.
- I or others in my health care provider practice group ("my Practice") have obtained written authorization from the patient named in this Enrollment Form that complies with the requirements of the HIPAA Privacy Rule, 45 C.F.R. § 164.508, and authorizes me and my Practice, as well as the patient's health insurance plan(s), to disclose the patient's personal health information ("PHI"), including information relating to the patient's medical condition and prescription medications and the information disclosed in this Enrollment Form to The Organon Access Program (the "Access Program"), and the Organon Patient Assistance Program ("Organon PAP") (individually, "a Program"; collectively, "the Programs"), and the administrators of the Programs, its affiliates, contractors and other third parties providing services related to these programs (collectively, "Program Administrators"), and authorizes the Programs and its Program Administrators to use and disclose the PHI for purposes of benefits investigation and reimbursement support.
- I certify that I, or a health care provider in my Practice, have determined that the prescribed product is medically appropriate for the patient identified above and that I, or a health care provider in my Practice, will be supervising the patient's treatment.
- If the patient receives product through the Organon PAP, neither I nor my Practice will seek reimbursement for such product administered to the patient from any source.
- Neither I nor my Practice will receive any reimbursement from Organon, whether for administration fees or otherwise.
- I understand that information concerning Program participants may be summarized for statistical or other purposes and provided to Organon and/or the Programs only for use in an aggregated, de-identified format.
- I and my Practice grant the Programs the right to conduct periodic audits of my Practice's records to verify the information provided herein, excluding patient-identifiable data (unless the auditor enters into an appropriate agreement with the Practice to protect an individual's medical privacy).
- I consent to receive communications related to the Program by telephone, email, and/or fax.
- I understand that the Program reserves the right to modify or discontinue this program at this facility/practice, or terminate assistance at any time and without notice.
- I verify that the information provided is complete and accurate to the best of my knowledge.

HEALTH CARE PROVIDER CERTIFICATION: THE ORGANON CO-PAY ASSISTANCE PROGRAM

I, a licensed health care professional, certify that I have prescribed the Program Product to the patient indicated on this form in the exercise of my independent medical judgment for an FDA-approved indication.

I have read and agree to the Terms and Conditions of the Co-pay Assistance Program. I certify that, to the best of my knowledge, the patient meets the criteria set forth in the Terms and Conditions, and that the information I am providing on this form is true and correct.

I certify that I/my office will not take into account the fact that the patient may receive a benefit from the Co-pay Assistance Program when determining the amount of any charge(s) to the patient. I certify that I/my office will not charge the patient any fee to complete this form and I/my office will not advertise or otherwise use the Co-pay Assistance Program as means of promoting my services or the Program Product.

I certify that the claim I submit/my office submits to the patient's private health insurer for payment of the Program Product will have the Program Product listed separately from any claim for medication administration or any other items or services provided to the patient.

I understand that I am/my office is responsible for reporting receipt of Co-pay Assistance Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Co-pay Assistance Program, as may be required.

I certify that I/my office will not seek reimbursement for all or any part of the benefit received by the patient through the Co-pay Assistance Program.

I understand that the patient's benefit received under the Co-pay Assistance Program will be paid directly to me/my office by the Co-pay Assistance Program on behalf of my patient. I/my office will apply any amounts received from the Co-pay Assistance Program to the satisfaction of the patient's obligation for the cost of the Program Product only. If I/my office already received payment from the patient for the patient's share of the cost of the Program Product for which the patient receives a benefit through the Co-pay Assistance Program, I/my office will refund the amounts received (minus the patient's obligation per administration in accordance with the Program Terms and Conditions) back to the patient.

I understand and agree that the certifications I am providing in this Health Care Provider Certification apply to the patient indicated on this form and to any other patient enrolled in the Co-pay Assistance Program who I treat with the Program Product and any claim I submit/my office submits for Co-pay Assistance Program benefits on the patient's behalf. I understand that I may be asked to sign a new Health Care Provider Certification if the Terms and Conditions of the Co-pay Assistance Program for the Program Product changes.

By signing, I certify that I have read and agree to the above Attestation. I also have read and agree to the above Certification (if applicable based on the support my patient requested) on behalf of the health care provider and all health care providers associated with the Practice/facility Tax Identification Number, Practice/facility name, and address associated with this Certification ("Recipient"). All health care providers affiliated with the Practice/facility may be jointly and severally liable hereunder. I further certify that I am authorized to make such attestation on behalf of the Recipient. The Certification above is not an exhaustive list and the Recipient agrees to comply with any other applicable laws, statutes, and regulations in regards to co-pay reimbursement programs.

HEALTH CARE PROVIDER SIGNATURE

Health care provider signature:_____ **Date:**_____

The health care provider must sign here.

Health care provider name (please print):_____

Health care provider designation (MD, DO, NP, PA, Other):_____

Date is required.

To report an adverse event to a specific Organon product, including death due to any cause, please contact the Organon Service Center at 844-674-3200.

ORGANON