Enrollment Application for the Vanda Patient Assistance Program

Dear Patient and Health Care Professional:

Thank you for your interest in the Vanda Patient Assistance Program.

To be eligible for the program, patients must:

- Be a US resident
- Meet the income requirements ***and***
- Have no prescription coverage

Applying to enroll in the Vanda Patient Assistance Program is easy!

1. Health Care Professional (HCP) completes and signs Prescriber Form (page 2)
2. Patient completes and signs Patient Form (pages 3-4)
3. Patient attaches copies of all required financial documentation
4. Mail or fax completed forms with financial documentation to:

Vanda Patient Assistance Program
PO Box 5823
Louisville, KY 40255

1 (844) 826-3203
If the application is faxed, it must be sent with a cover sheet and from the HCP's office.

We will review and process applications once we receive the completed form with supporting financial documentation. Patients will receive a letter regarding their status shortly thereafter.

If you have any questions, please call the Vanda Patient Assistance Program at 1 (844) 826-3200, Monday through Friday, 9:00AM to 8:00PM Eastern Standard Time.

You can also access a printable version of this enrollment application online at vandapharma.com.

Prescriber Form

VANDA PHARMACEUTICALS INC.

Enrollment Application for the Vanda Patient Assistance Program

PO Box 5823
Louisville, KY 40255

PAP Phone #: 1 (844) 826-3200
PAP Fax #: 1 (844) 826-3203

TO BE COMPLETED BY THE HCP

HCP's Full Name: _____ Phone: _____ Fax: _____

Address: _____ Email: _____

_____ DEA/State License #: _____

City: _____ State: _____ ZIP: _____ NPI #: _____

Patient's Full Name: _____ Product: **FANAPT® (iloperidone)**

Patient's Date of Birth: _____ Patient is new to FANAPT®: ☐ Y ☐ N

Please list patient's allergies: Patient is currently on FANAPT®: ☐ Y ☐ N

☐ No known If patient is on FANAPT®, next refill date is _____

_____ Strength: _____ Quantity: _____

_____ Directions: _____

_____ Refills: ☐ One year or: _____

Please list any other medications the patient is currently taking:

☐ None **Physician Signature**:

_____ ☐ _____ _____

_____ Substitutions permitted Date

_____ ☐ _____

_____ Dispense as written

_____ **NOTE: IF REQUIRED BY YOUR STATE (IE, NY & DE), PLEASE FAX AN ORIGINAL PRESCRIPTION BLANK.**

_____

Read and Sign HCP Authorization

I certify to the following: (1) Treatment with this medicine for this patient is medically necessary, based on my independent clinical judgment; (2) Information that I provide to Vanda Pharmaceuticals, Inc. and/or its representatives, agents and contractors (collectively, "Vanda") on this form, is complete and accurate; (3) I have the authority to disclose this patient's information and I have obtained, if required by HIPAA or other applicable privacy laws, this patient's authorization; (4) To the best of my knowledge, this patient meets Vanda's eligibility criteria for the PAP; (5) The medication requested above shall only be used to treat this patient and I shall not seek reimbursement for this medication from any third party. I acknowledge that I have assisted the patient in enrolling in the Vanda PAP exclusively for purposes of patient care and not in consideration for, expectation of, or actual receipt of remuneration of any sort.

SIGN HERE _____ _____

Prescriber Signature *Date*

Patient Form

Enrollment Application for the Vanda Patient Assistance Program

PO Box 5823
Louisville, KY 40255

PAP Phone #: 1 (844) 826-3200
PAP Fax #: 1 (844) 826-3203

Patient's Name:_____

Address:_____

City: _____ State: _____ ZIP: _____

Phone: _____

Cell Phone: _____

Email: _____

US Resident: ☐ Y ☐ N **Gender**: ☐ M ☐ F **Veteran**: ☐ Y ☐ N

Disabled: ☐ Y ☐ N (Status as deemed by Social Security)

Social Security/ID #:_____

Date of Birth: _____

Patient Advocate's Name: _____

Address:_____

City: _____ State: _____ ZIP: _____

Phone: _____

Email: _____

FINANCIAL INFORMATION:

Attach a copy of your household's most recent year tax returns (1040, 1040EZ, 1099, etc.)

Do not send original documents with your application.

Total # of people in the home (including yourself)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or more

# of Children: _____ # of Adults: _____

List all sources of Gross Monthly Income:

Salary/Wages (All Sources): $ _____

Pension/Retirement: + $ _____

Social Security: + $ _____

Disability: + $ _____

Unemployment Benefits: + $ _____

Alimony/Child Support: + $ _____

Total Gross Monthly Household Income = $ _____

PATIENT INSURANCE INFORMATION: Please include a copy of the front and back of your Prescription Card and Insurance Card

	Medical Coverage	Identification Number	Phone Number	Effective Date
Medicare Part A	☐ Y ☐ N			
Medicare Part B	☐ Y ☐ N			
Medicare Part D	☐ Y ☐ N			
Medicaid	☐ Y ☐ N			
State Elderly Drug Assistance	☐ Y ☐ N			
State Children Health Insurance	☐ Y ☐ N			
Veterans Assistance	☐ Y ☐ N			
Private Insurance	☐ Y ☐ N			
Other	☐ Y ☐ N			

DON'T FORGET TO READ AND SIGN PATIENT AUTHORIZATIONS ON NEXT PAGE BEFORE YOU SUBMIT

Patient Authorizations

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Vanda Patient Assistance Program

PO Box 5823
Louisville, KY 40255

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READ AND SIGN PATIENT AUTHORIZATIONS

Authorization for Disclosure of Personal Health Information by Providers and Insurers

I authorize (give my permission for) my doctor(s), other health care providers, their staffs, and my past or present health plans and insurers, if any, to disclose my personal information, including information about my insurance, prescriptions, medical condition, treatment and health ("Personal Health Information") to Vanda Pharmaceuticals, Inc. and/or its representatives, agents and contractors (collectively, "Vanda") so that Vanda can decide if I am eligible for the Vanda Patient Assistance Program ("PAP"); operate the PAP; send me information about the PAP and other programs that might help me pay for my medicines; send my information to other programs that might help me pay for my medicines; and contact me to seek further financial, insurance and/or medical information, discuss my participation in the PAP, confirm my receipt of medication, or otherwise administer the PAP. I understand that once my information has been disclosed, privacy laws may no longer restrict its use or disclosures, but Vanda will use and disclose my information only as described in this authorization or as required by law. I understand that if I do not sign this authorization, I will not be able to participate in the PAP, but my refusal to sign will not otherwise affect my ability to get medical care or seek payment for medical care or affect my enrollment in or eligibility for insurance. I understand that I can cancel this authorization at any time by calling the PAP at 1 (844) 826-3200, but that a cancellation will not apply to any information already used or disclosed in reliance on this authorization before I have called to cancel. I understand that I have the right to receive a copy of this authorization from my physician. This authorization expires in ten (10) years from the date signed below or earlier, if required by state law.

SIGN HERE ❯ _____ _____ **OR** _____ _____

Patient Signature *Date* *Personal Representative's Name (Print)* *Date*

_____

Personal Representative's Signature

_____

Authority of Personal Representative

Other Authorizations and Representations

I authorize (give my permission for) Vanda Pharmaceuticals, Inc. and/or its representatives, agents and contractors (collectively, "Vanda") to use and disclose the information that I have provided on this Application form, any information that I may later provide to Vanda, and any information Vanda receives from my doctor(s), other health care providers, their staffs, and my past or present health plans and insurers, if any, to decide if I am eligible for the Vanda Patient Assistance Program ("PAP"); operate the PAP; send me information about the PAP and other programs that might help me pay for my medicines; send my information to other programs that might help me pay for my medicines; and contact me to seek further financial, insurance and/or medical information, discuss my participation in the PAP, confirm my receipt of medication, or otherwise administer the PAP. I understand that, in carrying out these purposes, Vanda may disclose my information to government agencies, including the Centers for Medicare and Medicaid Services; insurance companies, including Medicare Part D plans; my doctor(s) and other people, or institutions who are involved in my healthcare, such as pharmacies and hospitals; and other organizations that might help me pay for my medication.

I represent that any information, including financial and insurance information, that I provide to Vanda is complete and true and, unless I have said something different in this Application, I have no insurance coverage for this prescription, including under Medicaid, Medicare or any public or private assistance programs or any other form of insurance. If my income or health coverage changes, I will call the PAP promptly at 1 (844) 826-3200.

If I am approved to participate in the PAP, I agree that I will not seek reimbursement from anyone else, including from an insurer, government health program, or a charity, for the free medicine I receive from the PAP. I will not seek to have this medicine, or any cost from it, counted in my Medicare Part D out-of-pocket expenses for prescription drugs. I will not seek reimbursement or credit for the medicine from my prescription insurance provider or payor, including Medicare Part D plans, for any costs of medication.

I understand that Vanda may change or end the PAP at any time, with or without notice. I understand that if I do not sign this form, I will not be able to participate in the PAP but this will not affect my ability to get medical care or seek payment for medical care or affect my enrollment or eligibility for insurance. I understand that I can cancel this authorization at any time by calling the PAP at 1 (844) 826-3200, but that a cancellation will not apply to any information already used or disclosed in reliance on this authorization before I called to cancel. This authorization expires ten (10) years from the date signed below or earlier, if required by state law.

SIGN HERE ❯ _____ _____ **OR** _____ _____

Patient Signature *Date* *Personal Representative's Name (Print)* *Date*

_____

Personal Representative's Signature

_____

Authority of Personal Representative