BYSANTI™ (milsaperidone) tablets

BYSANTI™ (milsaperidone) Patient Assistance Program Enrollment Application

Dear Patient and Health Care Professional:

Thank you for your interest in the BYSANTI™ (milsaperidone) Patient Assistance Program. To be eligible for the program, patients must meet all three of the following criteria:

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

HOW TO APPLY

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:

MAIL TO:

BYSANTI™ (milsaperidone) Patient Assistance Program
Vanda PAP
PO Box 99298
Jeffersontown, KY 40269

FAX TO:

1 (833) 933-9335

If the application is faxed, it must be sent with a cover sheet and from the HCP's office.

NEED HELP?

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 BYSANTI™ (milsaperidone) Patient Assistance Program at **1 (833) 933-9332,** Monday through Friday, 9:00 AM to 8:00 PM Eastern Standard Time.

You can also access a printable version of this enrollment application online at: vandapharma.com/products-and-pipeline

Please see Important Safety Information, including BOXED WARNING, and full Prescribing Information on BYSANTI.com.

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Prescriber Form

BYSANTI™ (milsaperidone) tablets

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PO Box 99298
Jeffersontown, KY 40269

PAP Phone #: 1 (833) 933-9332

PAP Fax #: 1 (833) 933-9335

1 PRESCRIBER INFORMATION

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

Address: _____ Email: _____

_____ DEA/State License #: _____

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

2 PATIENT INFORMATION

Patient's Full Name: _____

Patient's Date of Birth: _____

Please list patient's allergies:

☐ No known

_____

_____

_____

Please list any other medications the patient is currently taking:

☐ None

_____

_____

_____

_____

_____

3 PRESCRIPTION INFORMATION

Product: **BYSANTI™ (milsaperidone)**

Patient is new to BYSANTI™: ☐ Yes ☐ No

Patient is currently on BYSANTI™: ☐ Yes ☐ No

If patient is on BYSANTI™, next refill date is: _____

Strength: _____ Quantity: _____

Directions: _____

Refills: ☐ One year or: _____

Physician Signature:

☐ _____ _____
Substitutions permitted Date

☐ _____
Dispense as written

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

4 HCP AUTHORIZATION

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 BYSANTI™ (milsaperidone) PAP exclusively for purposes of patient care and not in consideration for, expectation of, or actual receipt of remuneration of any sort. I understand that any product or support provided at no cost through the PAP will not be billed to the patient or any third-party payor and does not obligate me to prescribe, purchase, or recommend any Vanda product.

SIGN HERE _____ _____
Prescriber Signature Date

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Patient Form

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PO Box 99298
Jeffersontown, KY 40269

PAP Phone #: 1 (833) 933-9332

PAP Fax #: 1 (833) 933-9335

1 PATIENT INFORMATION

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)

Date of Birth: _____

2 PATIENT ADVOCATE INFORMATION

Patient Advocate's Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

Email: _____

3 FINANCIAL INFORMATION

Attach a copy of your household's most recent year's 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 =$ _____

4 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			
Medicare Advantage	☐ Y ☐ N			
Medicaid	☐ Y ☐ N			
State Elderly Drug Assistance	☐ Y ☐ N			
State Children's Health Insurance (Program)	☐ 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 ›

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Patient Authorizations

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1 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 BYSANTI™ (milsaperidone) 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 (833) 933-9332, 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 ›

_____ Patient Signature

_____ Date

OR

_____ Personal Representative's Name (Print)

_____ Date

_____ Personal Representative's Signature

_____ Authority of Personal Representative

2 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 BYSANTI™ (milsaperidone) 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 (833) 933-9332.

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 (833) 933-9332, 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 ›

_____ Patient Signature

_____ Date

OR

_____ Personal Representative's Name (Print)

_____ Date

_____ Personal Representative's Signature

_____ Authority of Personal Representative

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