

The information you provide will be used by Vanda Pharmaceuticals Inc., our affiliates, and our service providers for the patient's enrollment and participation in PONVORYSolutions, a Vanda Patient Support Program offering access, affordability, and treatment support for patients. You may withdraw by calling 833-933-9331. By providing the information and submitting this form, you indicate that you read, understand, and agree to these terms.

## 1 PATIENT INFORMATION (Required)

FULL NAME\* DATE OF BIRTH\* / / SEX\* M F  
ADDRESS\* PHONE\* OK TO LEAVE VOICEMAIL\*  
CITY, STATE, ZIP\* EMAIL LANGUAGE

## 2 INSURANCE INFORMATION (Required. Please fill out this section in its entirety or provide a copy of the front and back of insurance cards.)

See attached copy of front & back of insurance card(s). This section is now complete.

I do not have prescription drug insurance

PRESCRIPTION INSURANCE CARRIER\*

Rx MEMBER ID\*

Rx GROUP ID

Rx PCN (if applicable)

Rx BIN (if applicable)

## 3 BASELINE ASSESSMENTS

This section may be left blank if baseline assistance is not being requested. If this section is left blank, the healthcare provider completing this form represents that the patient has been or will be cleared for therapy prior to initiation, and that product may be shipped.

### ASSISTANCE REQUESTED TO CONDUCT THE FOLLOWING AT THE PATIENT'S HOME:

If requesting assistance, a Baseline Assessment Clearance Form will be required upon review and approval of the results.

CBC LFT VZV ANTIBODY SEROLOGY OPTHALMIC EVALUATION ECG

### First Dose Monitoring is (please check one):

Not required

Required. I confirm I have counseled my patient on first dose monitoring requirements as described in the Prescribing Information.

## 4 DIAGNOSIS & PRESCRIPTION(S)

PRIMARY DIAGNOSIS ICD 10 G35 Multiple Sclerosis OTHER

HAS YOUR PATIENT ALREADY RECEIVED PONVORY? NO YES, INITIATED (MM/YY)

### TRIAL OFFER FOR PONVORY®

**Trial Offer:** By checking this box, I indicate that I would like to enroll my patient in the Trial Offer program. I understand that the patient may be contacted by PONVORYSolutions to initiate therapy and schedule shipping of his/her medication.

- Dispense one Starter Pack (14 tablets/pack); follow titration schedule on pack starting with Day 1.
- Dispense one 20-mg bottle (30 tablets/bottle); 1 tablet taken orally once a day starting after completion of Starter Pack.

### PHARMACY PRESCRIPTION (Complete this section if requesting enrollment in Vanda Bridge for PONVORY® AND/OR a pharmacy prescription)

**For Patients that are restarting or not receiving the Trial Offer:** Dispense one Starter Pack (14 tablets/pack); follow titration schedule on pack starting with Day 1.

**PONVORY® 20 mg once daily:** Dispense one 20-mg bottle of PONVORY® (30 tablets per bottle), 1 tablet taken orally once a day. REFILLS:

Dispense three 20-mg bottles of PONVORY® (30 tablets per bottle), 1 tablet taken orally once a day. REFILLS:

### SHIP TO\*:

Patient (see page 1) Prescriber (see above) First dose monitoring site (Input address below or leave blank and a PONVORYSolutions Care Coordinator will call you.)

SITE NAME SITE CONTACT  
ADDRESS CITY STATE ZIP

\*Confirmation that all pretests are completed will be required prior to shipping.

## 5 PRESCRIBER INFORMATION (Required)

PRESCRIBER NAME (FIRST, LAST)

SITE NAME SITE CONTACT  
ADDRESS CITY STATE ZIP  
EMAIL PHONE FAX  
NPI# STATE LICENSE # (OPTIONAL) TAX ID # PTAN (OPTIONAL)

**PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with PONVORY® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current PONVORY® full Prescribing Information. I authorize PONVORYSolutions to transmit the above prescription(s) to the appropriate pharmacy(ies) designated by me, the patient, or the patient's plan.**

(NO STAMPS ALLOWED)

DATE

Please see full [Prescribing Information](#) and [Medication Guide](#) for PONVORY®. Provide the Medication Guide to your patients and encourage discussion.

PATIENT NAME

EMAIL

PONVORY *Solutions* assists healthcare providers (HCPs) in the determination of whether treatment could be covered by the applicable third party payer based on coverage guidelines provided by the payer, and patient information provided by the HCP under appropriate patient authorization following the provider's exclusive determination of medical necessity. This information and assistance are made available as a convenience to patients, and there is no requirement that patients or HCPs use any Vanda product in exchange for this information or assistance. Vanda assumes no responsibility for and does not guarantee the quality, scope, or availability of the information and assistance provided. Each HCP and patient is responsible for verifying or confirming any information provided. All claims and other submissions to payers should be in compliance with all applicable requirements.

### Vanda PDS Program for PONVORY™

Vanda PDS Program for PONVORY™ enables eligible patients to receive PONVORY® (ponesimod) at no cost until they receive coverage or for up to 24 months from program enrollment, whichever comes first, if these requirements are met. See program requirements below and on the previous page.

### Vanda PDS Program for PONVORY™ Requirements

- You have been prescribed PONVORY® for an on-label, FDA-approved indication
- You have commercial insurance that has delayed (>5 business days) or denied their treatment
- You do not use any state or federal government-funded healthcare program to cover medication costs. Examples of these programs are Medicare, Medicaid, TRICARE, Department of Defense, and Veterans Administration
- You cannot submit the value of the free product as a claim for payment to any health plan
- You are not eligible if the prior authorization is denied due to missing information on coverage determination form, use for a non-FDA-approved indication or invalid clinical rationale
- You have signed a Vanda Patient Support Program Patient Authorization Form
- You must contact the program if you switch from commercial health insurance to a government-funded healthcare program

### How Vanda PDS Program for PONVORY™ Works

- Patients are eligible until they receive coverage or for up to 24 months of coverage from program enrollment, whichever comes first
- Program covers the cost of therapy only - not any associated assessments including pretests, first dose observations, or administration costs
- The value of the free product will not count towards the patient's out-of-pocket cost-sharing obligations
- Program good only in the United States and its territories. Void where prohibited, taxed, or limited by law
- Program terms may change

### By participating in Vanda PDS Program for PONVORY™, I authorize PONVORYSolutions to:

- Conduct a benefits investigation and confirm prior authorization requirements
- Provide prior authorization form assistance and status monitoring, including the exceptions and appeals processes
- Coordinate shipment of PONVORY® from the program Specialty Pharmacy to eligible patients at no charge until they receive coverage or for a maximum of 24 months from program enrollment, whichever comes first
- Support the transition of patients to commercial product if the medication is covered
- Check insurance coverage annually for patients enrolled in the program and any time for patients who have coverage change to confirm they are still eligible for the program

By checking this box I certify that I meet the requirements described above and would like to enroll in the Vanda PDS Program for PONVORY™. I have read, understand, and agree to the terms and conditions above.

PATIENT SIGN HERE

DATE / /

If the patient cannot sign, patients legally authorized representative must sign below:

BY

DATE / /

Describe relationship to patient and authority to make medical decisions for patient:

**Patients should read the Patient Authorization and return the completed form to the Vanda Patient Support Program. Completed forms may be faxed to (833)533-5330 or mailed to 2200 Pennsylvania Avenue NW #300e, Washington, DC 20037**

PATIENT NAME

EMAIL

**I give permission for each of my "Healthcare Providers" (eg, my physicians, pharmacists, specialty pharmacies, other healthcare providers, and their staff) and "Insurers" (eg, my health insurance plans) to share my Protected Health Information with the following person(s) or class of person(s) (collectively "Vanda"):**

- Vanda Pharmaceuticals Inc., its affiliated companies, agents, and representatives
- Providers of other sources of funding include foundations and co-pay assistance providers
- Service providers supporting or analyzing data from Vanda patient support programs

**My "Protected Health Information" includes information related to my medical condition, treatment, prescriptions, health insurance coverage and claims.**

**Specifically, I give permission to Vanda to receive, use, and share my Protected Health Information in order to:**

- See if I qualify for, sign me up for, and contact me about Vanda patient support programs or non-Vanda patient assistance programs (if one or more programs apply to my treatment with PONVORY<sup>®</sup>)
- Manage the Vanda patient support programs
- Give me educational and adherence materials, information, and resources related to my Vanda medication in connection with Vanda patient support programs
- Communicate with my Healthcare Providers regarding access to, reimbursement for, and fulfillment of my Vanda medication, and to confirm to my Healthcare Provider that support has been provided by the Vanda patient support programs
- Provide product support and adherence services, including online support, education and assistance services
- Verify, assist with, and coordinate my coverage for my Vanda medication with my Insurers and Healthcare Providers
- Coordinate prescription or treatment location and associated scheduling
- Conduct analysis to help Vanda evaluate, create, and improve its products, services, and customer support for patients prescribed Vanda medications
- Share and give access to information created by the Vanda and non-Vanda patient support programs that may be useful for my care

**I understand that my Protected Health Information may also be shared by Vanda for the uses written in this Form to:**

- My Insurers
- My Healthcare Providers
- Any of the persons given permission to receive and use my Protected Health Information as mentioned above
- Any individual I give permission as an additional contact

PATIENT SIGN HERE

If the patient cannot sign, patients legally authorized representative must sign below:

BY

Describe relationship to patient and authority to make medical decisions for patient:

I understand that after my Protected Health Information has been disclosed pursuant to this Authorization, my information may no longer be protected by federal health privacy laws. Vanda may share information about me where legally allowed or if any information that specifically identifies me is removed.

I appoint Vanda, including PONVORY Solutions, to act as my representative in connection with my insurance claim for PONVORY<sup>®</sup>. Authorize Vanda to make any request; prepare prior authorizations, appeals and any other information required for this claim; to present or elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead.

I understand that I am not required to sign this Form. My choice about whether to sign will not change how my Healthcare Providers or Insurers treat me. If I do not sign this Form, or if I cancel or remove my permission later, I understand I will not be able to participate or receive assistance from Vanda's patient support programs.

This Form will remain in effect 10 years from the date of signature, except where state law requires a shorter time, or until I am no longer participating in any Vanda patient support programs.

I understand that I may cancel the permissions given by this Form at any time by letting Vanda know in writing at: PONVORY Solutions, 2200 Pennsylvania Avenue NW #300e, Washington, DC 20037.

I can also cancel my permission by letting my Healthcare Providers and Insurers know in writing that I do not want them to share any information with Vanda.

I further understand that if I cancel my permission it will not affect how Vanda uses and shares my Protected Health Information received by Vanda prior to my cancellation.

I understand I may request a copy of this Form.

For privacy rights and choices specific to California residents, please see Vanda's California privacy notice available at <http://vandapharma.com/california-residents/>

DATE / /

DATE / /