

## Enrollment Application for the Fanapt® (iloperidone) Patient Assistance Program

### **Dear Patient and Health Care Professional:**

Thank you for your interest in the Fanapt®(iloperidone) 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 Fanapt® (iloperidone) 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:



#### **Fanapt® (iloperidone) 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 Fanapt® (iloperidone) 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/products-and-pipeline/](http://vandapharma.com/products-and-pipeline/)**

# Prescriber Form



## Enrollment application for the Fanapt® (iloperidone) Patient Assistance Program

PO Box 5823                    PAP Phone #: 1 (844) 826-3200  
Louisville, KY 40255            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: <b>FANAPT® (iloperidone)</b>
Patient's Date of Birth:	Patient is new to FANAPT®: <input type="checkbox"/> Y <input type="checkbox"/> N
Please list patient's allergies:	Patient is currently on FANAPT®: <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> No known	If patient is on FANAPT®, next refill date is _____
_____	Strength: _____ Quantity: _____
_____	Directions: _____
_____	Refills: <input type="checkbox"/> One year or: _____
_____	Physician Signature: _____
_____	<input type="checkbox"/> Substitutions permitted                    Date _____
_____	<input type="checkbox"/> Dispense as written
<b>NOTE: IF REQUIRED BY YOUR STATE (IE, NY &amp; DE), PLEASE FAX AN ORIGINAL PRESCRIPTION BLANK.</b>	

### 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 Fanapt® (iloperidone) 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



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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: _____
<b>US Resident:</b> <input type="checkbox"/> Y <input type="checkbox"/> N <b>Gender:</b> <input type="checkbox"/> M <input type="checkbox"/> F <b>Veteran:</b> <input type="checkbox"/> Y <input type="checkbox"/> N
<b>Disabled:</b> <input type="checkbox"/> Y <input type="checkbox"/> N (Status as deemed by Social Security)
Social Security/ID #: _____
Date of Birth: _____
<b>Patient Advocate's Name:</b> _____
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	= \$ _____

<b>PATIENT INSURANCE INFORMATION: Please include a copy of the front and back of your Prescription Card and Insurance Card</b>				
	<b>Medical Coverage</b>	<b>Identification Number</b>	<b>Phone Number</b>	<b>Effective Date</b>
Medicare Part A	<input type="checkbox"/> Y <input type="checkbox"/> N			
Medicare Part B	<input type="checkbox"/> Y <input type="checkbox"/> N			
Medicare Part D	<input type="checkbox"/> Y <input type="checkbox"/> N			
Medicaid	<input type="checkbox"/> Y <input type="checkbox"/> N			
State Elderly Drug Assistance	<input type="checkbox"/> Y <input type="checkbox"/> N			
State Children Health Insurance	<input type="checkbox"/> Y <input type="checkbox"/> N			
Veterans Assistance	<input type="checkbox"/> Y <input type="checkbox"/> N			
Private Insurance	<input type="checkbox"/> Y <input type="checkbox"/> N			
Other	<input type="checkbox"/> Y <input type="checkbox"/> N			

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

# Patient Authorizations



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Louisville, KY 40255            **PAP Fax #:** 1 (844) 826-3203

### 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 Fanapt® (iloperidone) 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**

Patient Signature

Date

**OR**

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 Fanapt® (iloperidone) 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**

Patient Signature

Date

**OR**

Personal Representative's Name (Print)

Date

Personal Representative's Signature

Authority of Personal Representative