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 private or public 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, 9:00 AM to 8:00 PM Eastern Standard Time.

You can also access a printable version of this enrollment application online at vandapharma.com.
Enrollment Application for the Vanda Patient Assistance Program

TO BE COMPLETED BY THE HCP

HCP’s Full Name: ___________________________ Phone: __________________ Fax: __________________
Address: __________________________________________ Email: ________________________________
_________________________________________________________________________________
_________________________________________________________________________________
City: ___________________ State: _______ ZIP: _______ NPI #: ________________________________

Patient’s Full Name: ___________________________ Product: FANAPT® (iloperidone)
Patient’s Date of Birth: ___________________________ Strength: ______________ Quantity: _______
Please list patient’s allergies:
☐ No known
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Please list any other medications the patient is currently taking:
☐ None
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Refills: ☐ One year or: ___________________________
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. 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
Enrollment Application for the
Vanda Patient Assistance Program

PO Box 5823 PAP Phone #: 1 (844) 826-3200
Louisville, KY 40255 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

<table>
<thead>
<tr>
<th>Medical Coverage</th>
<th>Identification Number</th>
<th>Phone Number</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part A</td>
<td>□ Y □ N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Part B</td>
<td>□ Y □ N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Part D</td>
<td>□ Y □ N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>□ Y □ N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Elderly Drug Assistance</td>
<td>□ Y □ N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Children Health Insurance</td>
<td>□ Y □ N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans Assistance</td>
<td>□ Y □ N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Insurance</td>
<td>□ Y □ N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>□ Y □ N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DON’T FORGET TO READ AND SIGN PATIENT AUTHORIZATIONS ON NEXT PAGE BEFORE YOU SUBMIT
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 or eligibility for insurance. 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 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.

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 drug insurance coverage, 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 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.

**VANDA and FANAPT are trademarks or registered trademarks of Vanda Pharmaceuticals Inc. in the United States and other countries. FANAPT® is licensed by Vanda Pharmaceuticals Inc. from Titan Pharmaceuticals, Inc. © 2015 Vanda Pharmaceuticals Inc. All rights reserved. Printed in the USA. FAN0014V2 03/15**