Ponvory® (ponesimod) once-daily tablets

PRESCRIPTION ENROLLMENT FORM

Complete and fax this form to PonvorySolutions at (833)533-5330

(833)-933-9331.
(833)-533-5330.
www.ponvorypro.com

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 PONVORY*Solutions*, 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 _____

☐ CONSENT TO RECEIVE TEXT MESSAGES

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 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) _____

4 DIAGNOSIS & PRESCRIPTION(s)

PRIMARY DIAGNOSIS ☐ ICD-10 G35 Multiple Sclerosis ☐ OTHER _____

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

☐ 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.

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.

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 PONVORY*Solutions* 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 PDS for PONVORY® AND/OR a pharmacy prescription)

☐ **PONVORY® 14-Day Starter Pack:**
Quantity: 1 Pack (14 Tablets) **Refills:** 0

Directions: Follow titration schedule on pack starting Day 1.

PRESCRIBER'S 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.

(Stamps/Electric Signatures Not Allowed)

PRESCRIBER SIGNATURE _____
(Dispense as written)

DATE _____

*In some states, interchange is mandated unless the practitioner indicates 'no substitution' in accordance with the law. Original signature is required – *If required by applicable law, please attach copies of all prescriptions on official state prescription forms*

☐ **PONVORY® 20 mg:**
Quantity: ☐ 30-Day Supply (#30 tablets) **Refills:** ____
☐ 90-Day Supply (#90 tablets) **Refills:** ____

Directions: Take 1 tablet orally once a day.

PRESCRIBER'S 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.

(Stamps/Electric Signatures Not Allowed)

PRESCRIBER SIGNATURE _____
(Dispense as written)

DATE _____

*In some states, interchange is mandated unless the practitioner indicates 'no substitution' in accordance with the law. Original signature is required – *If required by applicable law, please attach copies of all prescriptions on official state prescription forms*

SHIP TO*:

☐ Patient (see #1) ☐ Prescriber (see #3) ☐ First dose monitoring site (Input address below or leave blank and a PONVORY*Solutions* 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.

Please see full Prescribing Information and Medication Guide for PONVORY®. Provide the Medication Guide to your patients and encourage discussion.

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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 Payer Delayed Services (PDS) for PONVORY®

Vanda PDS 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 Payer Delayed Services (PDS) for PONVORY® Program 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. If coverage is denied, your HCP must challenge the denial with an exception, letter of Medical Necessity, or an appeal within 90 days.
- 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 Payer Delayed Services (PDS) 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 Payer Delayed Services (PDS), 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 for PONVORY® Program. 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:

Please see full Prescribing Information and Medication Guide for PONVORY®. Provide the Medication Guide to your patients and encourage discussion.

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VANDA PATIENT SUPPORT PROGRAM
PATIENT AUTHORIZATION FORM

(833)-933-9331.
(833)-533-5330.
www.ponvorypro.com

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®)
- 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

I understand that select pharmacies may receive remuneration from Vanda in exchange for my Protected Health Information and/or for Vanda patient support activities provided to me.

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 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/

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:

I appoint Vanda, including PONVORY*Solutions*, to act as my representative in connection with my insurance claim for PONVORY®. I 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.

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: