Prescription & Service Request Form

Prescribing HETLIOZ® (tasimelteon): An Instructional Guide

HETLIOZ® (tasimelteon) is indicated for the treatment of Non-24-Hour Sleep-Wake Disorder (Non-24) and Nighttime Sleep Disturbances in Smith-Magenis Syndrome (SMS).
Please see full Prescribing Information.

Completing the Prescription and Service Request Form

1 Patient Information

- Complete the First Name, Last Name, D.O.B., Address, City, State, and Preferred Phone fields

2 Insurance Information

- To ensure the prescription is filled, indicate whether the patient has insurance
- If the patient does have insurance, the Primary Medical Insurance and ID # fields must be completed
- It is recommended that you attach copies of both sides of the patient's pharmacy and insurance card(s)

3 Patient Signature

- Patient Services Authorization: If a patient wants to enroll in HETLIOZ*Solutions*®, he or she must sign this section
  - Before patients elect or decline to enroll, they must read section A on page 2, or an HCP or HCP staff member must read the section aloud to the patients
  - Please note that enrolling in HETLIOZ*Solutions*® is not required for a patient to receive his or her prescription, but the patient must be enrolled to be eligible for financial assistance and other programs
- Patient Marketing Authorization: If a patient wants to receive marketing materials for HETLIOZ®, he or she must sign this section
  - Before a patient signs this section, he or she must read section B on page 2, or an HCP or HCP staff member must read the section aloud to the patient
  - Please note that electing or declining to receive these materials does not affect a patient's eligibility to receive HETLIOZ® or enroll in HETLIOZ*Solutions*®

4 Prescriber Information

- Complete the Prescriber's Name, Phone Number, Fax Number, Address, City, State, and NPI # fields

5 Prescription Information and Prescriber Signature

- Indicate the dosage, quantity, refills, and any known patient allergies to the pharmacist filling a patient's prescription
  - Please note that daily use for several weeks or months may be necessary before benefit from HETLIOZ® is observed in patients with Non-24

6 Indicate Diagnostic Code(s)

- In order for HETLIOZ*Solutions*® and the specialty pharmacy to properly fill the prescription, the Diagnostic Code(s), Dispense, Prescriber Signature, and Prescriber Signature Date fields must be properly completed
- Many of the services offered by HETLIOZ*Solutions*® may only be available to patients with Non-24 and those with Nighttime Sleep Disturbances in Smith-Magenis Syndrome (SMS).

Fax the completed form to HETLIOZ*Solutions*® at 1-844-364-2424

- A Fax Receipt Confirmation will be provided from HETLIOZ*Solutions*®
- If any of the information is missing or incomplete, HETLIOZ*Solutions*® will fax a Missing Information Form

HETLIOZ*Solutions*® pairs a care coordinator with a patient and HCP to ensure a seamless experience from prescription through administration

- HETLIOZ*Solutions*® starts the process with an introduction call to the patient that occurs within 24 hours of receiving a patient's HETLIOZ*Solutions*® Prescription & Service Request Form, which includes confirming the patient's contact and prescription delivery information
- HETLIOZ® will be distributed only through specialty pharmacies

For more information on HETLIOZ® and the HETLIOZ*Solutions*® program, call **1-844-HETLIOZ (1-844-438-5469)** or visit **HETLIOZPRO.com**

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HETLIOZ*Solutions*® Prescription & Service Request Form

Fax completed form to 1-844-364-2424 Phone 1-844-HETLIOZ (1-844-438-5469) Please complete all fields to avoid any delays in processing.

1 Patient Information

First Name: ______ M.I.: ______ Last Name: ______ Sex: ☐ M ☐ F
E-mail: ______ Last 4 Digits of SSN: ______ D.O.B.: ______ Weight (lbs): ______
Address: ______ City: ______ State: ______ Zip: ______
Preferred Phone: ______ ☐ OK to leave message Alternate Phone: ______ ☐ OK to leave message
Blind: ☐ Yes ☐ No How would you like to receive information (select one): ☐ Braille ☐ Audio ☐ Print

2 Insurance Information

Does patient have insurance: ☐ Yes ☐ No (If yes, please select): ☐ Medicare Plan ☐ Medicaid Plan ☐ Other ______
Prescription Drug Insurer: ______ Bin #: ______ ID #: ______
Group #: ______ Phone: ______
Primary Medical Insurance: ______ Cardholder Name: ______
Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other ID #: ______ Group #: ______ Phone: ______
Secondary Medical Insurance: ______ Cardholder Name: ______
Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other ID #: ______ Group #: ______ Phone: ______

3 Patient Signature - Parents and Legal Guardians, please complete Section C on Page 2

Patient Services Authorization
I have read & agree to the Patient Services Authorization Section A on Page 2
(Signature and Date Required).

Sign Here

Signature: Patient / Parent / Legal Guardian ______ Date ______

Patient Marketing Authorization
I have read & agree to the Patient Marketing Authorization Section B on Page 2
(Signature and Date Required).

Sign Here

Signature: Patient / Parent / Legal Guardian ______ Date ______

4 Prescriber Information

Prescriber's Name: ______ Specialty: ______
Office Contact Name: ______ Phone: ______ Fax: ______
Address: ______ City: ______ State: ______ Zip: ______
Provider Tax ID #: ______ State License #: ______ Prescriber NPI #: ______

5 Prescription Information

☐ Rx: HETLIOZ®(tasimelteon) Adults (Non-24 and SMS)/ Children (SMS) ≥16 years old: capsules, 20mg
☐ Rx: HETLIOZ LQ™ (tasimelteon) Children (SMS) 3 to 15 years old: liquid suspension, 4 mg/ml

Dosing in Children with SMS 3 to 15 years old:	
Body Weight ≤ 28kg	Daily Dose (liquid suspension), 0.7mg/kg
Body Weight > 28kg	Daily Dose (liquid suspension), 20mg

Dispense:
☐ Hetlioz® 30 capsules, 11 refills
☐ Hetlioz® 90 capsules, 3 refills
☐ Hetlioz LQ™- 48ml, 11 refills
☐ Hetlioz LQ™- 158ml, 11 refills
☐ Known allergies ______

Sig: ______ po q24h (1 hour before bedtime at same time every night, without food)

I certify that this therapy is medically necessary and this information is accurate to the best of my knowledge. I certify that I am a physician who has prescribed HETLIOZ® to the previously identified patient. On behalf of my patient, I authorize Vanda Pharmaceuticals Inc. ("Vanda"), including Vanda's HETLIOZ*Solutions*® Program operated by RxC Acquisition Company d/b/a RxCrossroads, and/or RxCrossroads, and/or any other entity that subsequently operates the HETLIOZ*Solutions*® Program on behalf of Vanda (collectively "the Entities") to act for me, a covered entity, as my business associate (as that term is defined in 45 CFR 160.103) to [1] forward this information to the insurer identified above, [2] forward the above prescription information to a specialty pharmacy in order to dispense HETLIOZ® capsules or HETLIOZ LQ™ liquid suspension to the patient, and [3] otherwise use this information for the purpose of providing HETLIOZ*Solutions*® services to my patient, including contacting the patient directly to obtain the patient signature on any necessary authorization forms or other documents. By signing this form, I acknowledge that I have read the Business Associate Agreement ("BAA") at www.hetliozpro.com/BAA-policy. I agree to comply with the terms of the BAA and understand that the Entities have also agreed to comply with the terms of the BAA.

6 Indicate Diagnostic Code(s):

Primary (required):
☐ G47.24 CRSD, free-running type (Non-24)
☐ Q93.5 Smith-Magenis Syndrome
☐ Additional supporting information:
☐ H54.0 Blindness, both eyes

☐ Other ______
☐ Other ______

Sign Here

Prescriber Signature (Dispense as Written) ______ Date ______

Sign Here

Prescriber Signature (Substitution Allowed) ______ Date ______

Signature stamps not acceptable. Only valid if received by fax.

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HETLIOZ*Solutions*® Prescription & Service Request Form

Fax completed form to 1-844-364-2424 Phone 1-844-HETLIOZ (1-844-438-5469) Please complete all fields to avoid any delays in processing.

A. Patient Services Authorization

By signing this authorization, I authorize my health plans, physicians and staff, other healthcare providers, and pharmacy providers (collectively, my "Providers") to disclose personal health information about me, including information related to my medical condition, treatment, care management, and health insurance coverage and claims, any prescription (including fill/refill information), as well as information provided on this form (collectively, "Personal Health Information"), to Vanda Pharmaceuticals Inc. ("Vanda") and its representatives, agents, and contractors, including to Vanda's HETLIOZ*Solutions*® Program operated by RxC Acquisition Company d/b/a RxCrossroads ("RxCrossroads") on behalf of Vanda (collectively "the Entities") for the purposes of (1) establishing my eligibility for benefits; (2) enrolling me in a financial assistance program, such as a co-pay mitigation program and/or Vanda's patient assistance program or non-Vanda patient assistance program (if one or more of such programs apply to my treatment with HETLIOZ® or HETLIOZ LQ™ (hereafter "HETLIOZ®"); (3) communicating about my treatment with HETLIOZ® with my Providers, who may contact me directly to facilitate the dispensing of medication and scheduling shipments and refill reminders; (4) providing product support and adherence services; (5) evaluating the effectiveness of Vanda's HETLIOZ*Solutions*® Program; and (6) other online support, education, and assistance services (together, the "Services"). Further, I authorize any of the Entities to contact me by mail, telephone or e-mail to obtain any information not included in this authorization. I appoint Vanda Pharmaceuticals Inc. including HETLIOZ*Solutions*® to act as my representative in connection with my insurance claim for HETLIOZ®. 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. I understand that personal medical information related to my appeal may be disclosed to Vanda. I understand that my pharmacy provider(s) will disclose to Vanda and/or its representatives, agents, and contractors certain Personal Health Information regarding the dispensing of my HETLIOZ® prescription and that such disclosure will result in remuneration to my pharmacy provider(s). I understand that once my Personal Health Information is disclosed to the Entities under this authorization, it is no longer protected by Federal privacy laws and may be further disclosed by the Entities. However, I understand that Vanda agrees to protect my Personal Health Information and only use and disclose it for the purposes described above, or as I may further authorize in writing, or as permitted or required by law. I also understand that RxCrossroads, which operates HETLIOZ*Solutions*® Program for Vanda, and my Providers, including my physician and pharmacies may receive compensation from Vanda for providing such services or educational or product related information materials. I understand that I may refuse to sign this authorization. I understand, however, that if I do not sign this authorization, I will not be able to receive assistance through the HETLIOZ*Solutions*® Program. I further understand that my treatment with HETLIOZ®, payment for treatment, insurance enrollment or eligibility for insurance benefits are not conditioned upon my agreement to sign this authorization. I understand that I am entitled to a copy of this authorization. I understand that I may change my mind and cancel this authorization at any time by writing a letter requesting such cancellation to Vanda Pharmaceuticals, 2200 Pennsylvania Ave NW Suite 300E, Washington, D.C. 20037, but that this cancellation will end my participation in the HETLIOZ*Solutions*® Program and will not apply to any information already used or disclosed through this authorization before notice of the cancellation is received by my health plans or Providers. This authorization expires ten (10) years from the date signed below, or earlier, if required by state law.

B. Patient Marketing Authorization

I further authorize Vanda and the Entities to provide me information regarding education, training, and ongoing support on the use of HETLIOZ®, and that may be of interest to me. I authorize the release of information in this enrollment form to Vanda and the Entities to contact me with information regarding offers, services and programs, educational materials or promotional and product materials on the use of HETLIOZ®, to contact me occasionally to obtain feedback (for market research purposes) about Vanda, HETLIOZ®, or the HETLIOZ*Solutions*® Program, and to operate (and improve the quality of) the HETLIOZ*Solutions*® Program. I understand that, in order to provide me the information described above, Vanda and the Entities may use my information in this authorization to contact me by mail, telephone, or email. If I change my mind in the future and do not wish to receive information related to HETLIOZ® or any related products or services or to be contacted occasionally for market research purposes, I understand that I may call the HETLIOZ*Solutions*® toll free number, 1-844-438-5469 at any time to cancel this authorization.

C. Parents and Legal Guardians

I am over 18 years of age and either: (1) the parent of the above named patient who is a minor, or (2) the duly appointed legal guardian of the above named patient. I have read and responded to this Prescription and Service Request Form and provided the above authorizations on the patient's behalf.

Name: ______________________________ Sign Here ______________________________
Parent / Legal Guardian — Parent / Legal Guardian — Date

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