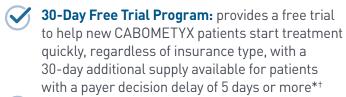
Access. Assistance. Along the Journey.



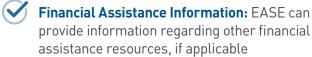
KEY INFORMATION TO COMPLETE AND SUBMIT THE EASE ENROLLMENT FORM

SERVICES AVAILABLE THROUGH EASE











Benefits investigation: EASE can investigate the patient's insurance coverage and payer requirements





Dose Exchange Program: provides a free 15-tablet supply in the lower dose to help patients who require a dose reduction.^{†§}



To request the Dose Exchange Program, download the form at <u>www.EASE.US</u> or scan the QR code

SUBMISSION CHECKLIST

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	Ensure all	reauirea	sections	or the	torm	are c	completed	and 9	sioneo
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- ☐ Check to make sure the **patient's name and date of birth** are provided on both pages of the form
- ☐ Include a copy of the patient's insurance card(s), both front and back
- ☐ Fax the form and copy of the insurance card(s) to 1-844-901-EASE (1-844-901-3273)
- ☐ Instruct patients to expect a call from RxCrossroads Specialty Pharmacy if the 30-Day Free Trial Program or PAP has been requested

PATIENT AUTHORIZATION

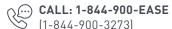
Patient Authorization can be obtained in 1 of 3 ways:

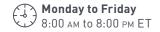
- An EASE Case Manager can reach out to the patient to facilitate the completion of the Patient Authorization Form via DocuSign
- A patient can submit the Patient Authorization Form online by going to the *Cost & Financial Support* tab at www.cabometyx.com or can print the form, complete it, and fax it in
- **HCP office staff** can have the patient complete and sign a paper Patient Authorization Form, then fax it to **1-844-901-EASE** (**1-844-901-3273**).



A copy of the form can be found at www.cabometyxhcp.com/resources or scan the QR code

[‡]The Co-Pay Program is not available to patients receiving prescription reimbursement under any federal, state, or government-funded insurance programs or where prohibited by law. Additional <u>Terms and Conditions</u> apply. [§]Patients are required to return any unused product.









^{*}Limited to on-label indications.

[†]Additional restrictions and eligibility rules apply.



EASE ENROLLMENT FORM



1 REQUESTED SERVICES (Check all that apply)	REQUIRED				
□ 30-Day Free Trial Program* □ Patient Assistance Program (PAP)* □ Benefits Investigation	☐ Prior Authorization/Appeals Assistance ☐ Prescription Triage to In-Network Specialty Pharmacy				
2 PATIENT INFORMATION	REQUIRED.				
Patient name:	Preferred contact method:				
3 PATIENT INSURANCE INFORMATION (Please in 3.1 Primary Medical Insurance Information	nclude copy of front and back of insurance card[s]) 3.2 Prescription Drug Insurance Information				
Commercial Medicare Other Government Program Uninsured (e.g., Medicaid, VA, TRICARE) Plan name: Policy #: Group #: Phone: Policyholder name: Relationship to policyholder:	Patient does not have prescription coverage Company name:				
4 PATIENT MEDICAL INFORMATION (Please comple					
4.1 Diagnosis Renal cell carcinoma (RCC) □ C64 Malignant neoplasm of kidney, except renal pelvis □ C64.1 Malignant neoplasm of right kidney, except renal pelvis □ C64.2 Malignant neoplasm of left kidney, except renal pelvis □ C64.9 Malignant neoplasm of unspecified kidney, except renal pelvis □ Combination therapy with nivolumab	Hepatocellular carcinoma (HCC) C22.0 Liver cell carcinoma C22.8 Malignant neoplasm of liver, primary, unspecified as to type Differentiated thyroid carcinoma (DTC) C73 Malignant neoplasm of thyroid gland Other diagnosis and ICD-10 code				
4.2 Line of Therapy for CABOMETYX® (cabozantinib) Prescrip	tion				
☐ First line ☐ Second or subsequent treatment 4.3 Current Medications and Allergies Current medications for selected diagnosis:	Drug and/or nondrug allergies: ☐ Yes ☐ No If Yes, please list drug allergies:				
5 PRESCRIBER INFORMATION	REQUIRED				
Prescriber name:	Practice name:				

*Additional restrictions and eligibility rules apply.

Please see full <u>Prescribing Information</u> for CABOMETYX.

Fax Completed and Signed Form to:



CALL: 1-844-900-EASE [1-844-900-3273]





FAX: 1-844-901-EASE [1-844-901-3273]



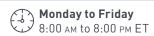


EASE ENROLLMENT FORM (CONT'D)



Patient last name: First nam	ie:	DOB:	//								
6 PRESCRIPTION FOR 30-DAY FREE T	RIAL PROGI	RAM* (Limited to NEW pation	ents with on-label indication only)								
REQUIRED FOR Please confirm patient is newly prescribed CABOMETYX® (cabozantinib) Yes No											
CABOMETYX dose ☐ 60 mg tablets ☐ 40 mg tablets ☐ 20 mg tablets	Directions Once daily	Quantity ☐ 30 tablets (per program guidelines)	Authorize refill ☐ 1 refill (limited to 1 refill for 5 day payer delay only)								
Complete prescription for the 30-Day Free Trial Program. A free 30-day supply of CABOMETYX will be dispensed and shipped to the patient. IMPORTANT: Please tell the patient to expect a call from RxCrossroads Specialty Pharmacy to obtain consent to ship the prescription. Please attach a separate prescription if this section does not comply with your state's prescription laws.											
Sign Here Dispense as written Prescriber full signature:			Date:/								
7 PRESCRIPTION FOR PAP* OR TRIAG	SE TO IN-NE	TWORK SPECIALTY PH	ARMACY								
IMPORTANT: In order for us to send medication to your patient, the prescription information below must be complete and accurate.											
CABOMETYX dose ☐ 60 mg tablets ☐ 40 mg tablets ☐ 20 mg tablets	Directions Once daily	Quantity 30 tablets tablet	Authorize refills s refills								
Please attach a separate prescription if this section does not comply with your state's prescription laws. Please check 1 box and sign on the line above it. Prescriber full signature: Dispense as written Dispense as written The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber. PRESCRIPTION FULFILLMENT In-office dispensing (IOD) pharmacy-prefer to dispense through an IOD pharmacy if possible IOD contact's name: IOD contact's phone: IOD contact's email: In-Network SP triage – request that EASE forward the prescription to the contracted or payer-mandated SP Prescriber triage – have already sent the prescription to the following pharmacy: ———————————————————————————————————											
By signing this form, I certify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge. I have prescribed CABOMETYX® based on my judgment of medical necessity and I will be supervising the patient's treatment. I have received the necessary legal authorization from the patient to transmit the patient's personal health information, as provided on this form, to EXELIXIS®, and parties working with EXELIXIS, so that they may (1) contact the patient at the patient's phone number(s) provided on this form and (2) perform a preliminary assessment of insurance verification and (3) determine patient eligibility for the EXELIXIS product program(s). I authorize the forwarding of this prescription to a dispensing specialty pharmacy on behalf of myself and the patient. I understand that neither I nor the patient may seek reimbursement from, submit claims to, or cause the submission of claims to any government program or third-party insurer for any free product received under the program(s). If applicable, any free product provided to me for the patient will be provided to the patient for his or her own use without charge and I will not sell, resell, or attempt to resell such product. Sign Here Prescriber full signature: Date: Date:											
Please see full Prescribing Information for CABOMETYX.											

CALL: 1-844-900-EASE [1-844-900-3273]



Fax Completed and Signed Form to:





