EASE EXELIXIS ACCESS SERVICES®

PATIENT AUTHORIZATION FORM

REQUIRED

Patient's Last Name: _____ First Name: _____ DOB: ____/____/____

Doctor's Name: _____

Patient's Home Phone: (_____) _____ - _____ Patient's Cell Phone: (_____) _____ - _____

☐ OK to leave a detailed message? ☐ OK to send a text message?

Patient's Email: _____ Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Alternate representative (optional)

Representative's Last Name: _____ First Name: _____

Relationship: _____ Phone: (_____) _____ - _____

1 PATIENT AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION: EASE

REQUIRED

By signing below, I authorize my healthcare providers, Exelixis, Inc. (Exelixis) and its representatives, agents, and contractors, including the EASE Program operated by RxCrossroads by McKesson on behalf of Exelixis and other specialty pharmacies contracted with Exelixis (collectively, the Entities) to use and share among themselves my personal health information (my PHI), which may include the information contained on the enrollment form, health insurance information and medical record information related to treatment with Exelixis products, for purposes of (1) providing the services offered by EASE (the program) including the Co-pay Assistance Program or Patient Assistance Program; (2) undertaking financial support services, including benefits verification, potential out-of-pocket costs, and eligibility for financial assistance; (3) to see if I qualify for patient assistance; (4) facilitating the dispensing of medication, supplies, or services by Exelixis; (5) providing product support and services; and (6) undertaking other online support, education, and assistance services. Further, to the extent I sign the optional Patient Authorization to Enroll in Additional Exelixis Support in Section 2, I authorize the Entities to use and disclose my PHI for the purposes contemplated therein. I understand that once my PHI is shared with certain Entities as described above, it may not remain protected by federal privacy law and could be disclosed to others. I understand that pharmacies may receive payment for the use and disclosure of my PHI as described in this authorization. I further authorize pharmacies to use my PHI to communicate with me about the medicinal product that has been prescribed for me and that they may receive a fee for such communication. I understand that I may refuse to sign this authorization and that if I do refuse, that it would not affect my rights to treatment or health benefits, but it would prevent me from enrolling in the EASE program. I also understand that I may cancel this authorization at any time by writing to EXELIXIS Access Services, PO Box 1749, Columbus, OH 43216-1749 and requesting such cancellation, but that any such cancellation will not affect the sharing and use of my PHI by the Entities before they actually receive notice of my cancellation. If I do not cancel this authorization earlier, it will remain valid for 5 years from the date of my signature below or the maximum period permitted by state law if less than 5 years. I understand that I have a right to receive a copy of this authorization when it is signed.

Please sign

Print Patient's or Representative's Last Name: _____ First Name: _____

Patient's or Representative's Signature: _____ Date: ____/____/____

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2 PATIENT AUTHORIZATION TO ENROLL IN ADDITIONAL EXELIXIS SUPPORT (OPTIONAL)

I authorize Exelixis and its agents (including service providers on its behalf) to provide me with information, including promotional and product materials, regarding offers, services, and programs, educational training and ongoing support on the use of Exelixis products that may be of interest to me, and to contact me with such information by mail, email, text message or telephone, including through an automatic telephone dialing system. You further authorize Exelixis to discuss Exelixis products and obtain feedback (for market research purposes). Exelixis or its service providers will de-identify personal information in accordance with applicable U.S. federal and state laws for such market research purposes.

I understand that I may opt out of these individual communications entirely at any time by calling 1-855-400-3935.

Please sign

Print Patient's or Representative's Last Name: _____ First Name: _____

Patient's or Representative's Signature: _____ Date: _____/_____/_____

3 EASE CO-PAY PROGRAM FOR COMMERCIALLY INSURED PATIENTS

(Complete **ONLY IF** you want to apply for the EASE Co-Pay Program.)

I authorize EASE to enroll me in the Co-Pay Assistance Program and to use my personally identifiable information related to my therapy for program administration. By signing below, I acknowledge and attest that I do not participate in any Medicaid, Medicare, or similar federal, state, or other government-funded benefit programs. I understand that personal information being provided and information pertaining to the use of the EASE Co-Pay Assistance Program at the pharmacy, such as the date the transaction was processed and the amount of co-pay that will be paid for by Exelixis, Inc., will be shared with Exelixis, Inc., the sponsor of the program, and its third party partners.

Please sign

I do not participate in any Medicaid, Medicare, or similar federal, state, or other government-funded benefit programs.

Print Patient's or Representative's Last Name: _____ First Name: _____

Patient's or Representative's Signature: _____ Date: _____/_____/_____

4 EASE PATIENT ASSISTANCE PROGRAM (PAP) FOR UNINSURED/UNDERINSURED PATIENTS

I understand that I am providing "written instructions" authorizing EASE Patient Assistance Program, Exelixis and its vendor, under the Fair Credit Reporting Act ("FCRA"), to obtain information from my credit profile or other information from Experian Health, for the purpose of determining financial qualifications for programs administered by EASE. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process. I promise that any information, including financial and insurance information that I provide, is complete and true. If my income or health coverage changes, I will call EASE at 844-900-3273. If eligible, I would like to be considered for programs administered by EASE.

Income limits apply. This information will only be used to determine eligibility for PAP. PAP applicants may be required to submit verification for all sources of household income. No party may seek reimbursement for any free drug provided to the patient under the EASE PAP. Free drug (1) may not count toward a patient's out-of-pocket costs under their insurance plan, such as the true out-of-pocket (TrOOP) under Medicare Part D and (2) is not contingent on any purchase.

Please sign

Social Security Number: _____ Annual Pre-Tax Household Income: _____ Number in Household: ___

Print Patient's or Representative's Last Name: _____ First Name: _____

Patient's or Representative's Signature: _____ Date: _____/_____/_____

CALL: 1-844-900-EASE
(1-844-900-3273)

Monday to Friday
8:00 AM to 8:00 PM (ET)

Fax Completed and Signed Form to:

FAX: 1-844-901-EASE
(1-844-901-3273)

VISIT: www.EASE.US

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