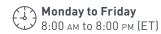


DOSE EXCHANGE FORM













The EASE Dose Exchange Program can help ensure the continuity of your patient's care by providing a lower dose when a dose adjustment is required.

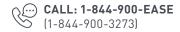
- Patients receive a onetime supply of 40-mg or 20-mg CABOMETYX® tablets to help them transition to a lower dose
- Provides 15 days of free product in the event a dose reduction is required
- Additional restrictions and eligibility rules apply
- Following receipt of the new dose, the patient is required to return the previously unused product to EASE. Return packaging for the unused product is provided to the patient with the new dose

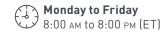
Patient Name:			DOB:			
1	PATIENT CONTACT IN	FORMATION			REQUIRED	
Street address:			Patient Representative/Caregiver (if applicable):			
City:						
State: ZIP:			Phone:			
Male Female			Relationship to patient:			
Cell phone:						
Home phone:						
Email address:						
Current da	aily dose (being discontinued): mg	Estimated remaining supply: days			
2 DOSE EXCHANGE PRESCRIPTION (NEW STRENGTH)						
CABOMETYX Dose		Directions		Dispense		
40 mg		QD		Fifteen (15) tablets		
20 mg						
Please atta	ach a separate prescription if t	this section does not d	comply with your state	's prescription laws.		
	Dispense as written					
Please sign			Date:			
	Prescriber Address:					
	Prescriber Phone:					
					1/2	



EASE EXELIVIS ACCESS SERVICESS DOSE EXCHANGE FORM











Patient Name:		DOB: _					
DOSE EXCHANGE PRESCRIPTION FOR SP REFERRALS AND PAP (Ongoing Refills) Complete ONLY IF you are requesting refills. This section is not required. Eligibility for Dose Exchange is not contingent on any purchase obligation.							
CABOMETYX Dose 40 mg 20 mg	Directions QD	Quantity Thirty (30) tablets tablets	Refillsrefills				
Please attach a separate pre	escription if this form does not	comply with your state's prescrip	tion laws.				
Please Dispense as wr sign Prescriber's Fu		Date:					
4 PRESCRIBER INFORMATION							
Prescriber's Name:		Practice's Name:					
Street address:		Specialty: Office Contact's Name: Office Contact's Email: Group NPI #: Tax ID #:					
 I agree to comply with the program guidelines as established by Exelixis Access Services I have explained to my patient that he or she must return the unused drug according to the instructions provided by EASE I will not submit a claim for payment for the exchanged products and will inform my patient not to submit a claim 							
Please attach a separate prescription if this form does not comply with your state's prescription laws.							
Please Dispense as wr sign Prescriber's Fu		Date	e:				
For CABOMETYX Dose Exchange (Pharmacy Use Only)							
Return authorization #: Case ID #		#:Orde	Order #:				
Number of unused tablets returned:							

Please see full Prescribing Information for CABOMETYX.

