EASE EXELIXIS ACCESS SERVICES® | DOSE EXCHANGE FORM

CABOMETYX® (cabozantinib) tablets
60 mg | 40 mg | 20 mg

CALL: 1-844-900-EASE (1-844-900-3273)
Monday to Friday 8:00 AM to 8:00 PM (ET)
FAX: 1-844-901-EASE (1-844-901-3273)
VISIT: www.EASE.US

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

REQUIRED

Patient Name: _____ **DOB:** _____

1 PATIENT CONTACT INFORMATION

REQUIRED

Street address: _____

_____

City: _____

State: _____ ZIP: _____

☐ Male ☐ Female

Cell phone: _____

Home phone: _____

Email address: _____

Patient Representative/Caregiver (if applicable):

_____

Phone: _____

Relationship to patient: _____

_____

Current daily dose (being discontinued): _____ mg

Estimated remaining supply: _____ days

2 DOSE EXCHANGE PRESCRIPTION (NEW STRENGTH)

REQUIRED

CABOMETYX Dose	Directions	Dispense
☐ **40** mg ☐ **20** mg	QD	☐ Fifteen (15) tablets

Please attach a separate prescription if this section does not comply with your state's prescription laws.

Please sign

☐ Dispense as written

Prescriber's Full Signature: _____ **Date:** _____

Prescriber Address: _____

Prescriber Phone: _____

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REQUIRED

Patient Name: _____ **DOB:** _____

3 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	Directions	Quantity	Refills
☐ **40** mg ☐ **20** mg	QD	☐ Thirty (30) tablets ☐ _____ tablets	☐ _____ refills

Please attach a separate prescription if this form does not comply with your state's prescription laws.

Please sign

☐ Dispense as written

Prescriber's Full Signature: _____ **Date:** _____

4 PRESCRIBER INFORMATION

REQUIRED

Prescriber's Name: _____

Street address: _____

City: _____

State: _____ ZIP: _____

Phone: _____ Fax: _____

State license #: _____

DEA #: _____

Prescriber's NPI #: _____

Practice's Name: _____

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 sign

☐ Dispense as written

Prescriber's Full Signature: _____ **Date:** _____

For CABOMETYX Dose Exchange (Pharmacy Use Only)

Return authorization #: _____ Case ID #: _____ Order #: _____

Number of unused tablets returned: _____

Please see full Prescribing Information for CABOMETYX.

EXELIXIS®

 ACC-0044 02/18