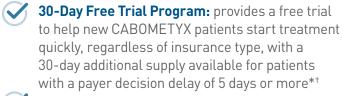
Access. Assistance. Along the Journey.



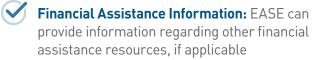
KEY INFORMATION TO COMPLETE AND SUBMIT THE EASE ENROLLMENT FORM

SERVICES AVAILABLE THROUGH EASE











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



EASE prescription triage to specialty pharmacy (SP): EASE can forward the prescription to the in-network SP

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 www.EASE.US or scan the QR code

SUBMISSION CHECKLIST

\neg	Ensure all				f				_:
- 1	Ensure all	required	sections	orthe	torm a	are cor	nnieten	ann	sianea
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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) or attach insurance card(s) if using Docusign
- ☐ Advise PAP applicants that **proof of income will be requested**
- □ Instruct patients to expect a call from CoverMyMeds 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 Forms & Documents tab at www.EASE.US 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.EASE.US/forms-documents or scan the QR code

§Patients are required to return any unused product.









^{*}Limited to on-label indications

[†]Additional restrictions and eligibility rules apply.

[†]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 Terms and Conditions apply.

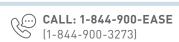


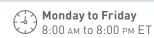
EASE ENROLLMENT FORMEASE ENROLLMENT FORM



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:	Email: Preferred contact method:
3 PATIENT INSURANCE INFORMATION (Please	include copy of front and back of insurance card[s])
3.1 Primary Medical Insurance Information	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:
4.1 Diagnosis ICD-10 code:	RECOINED
☐ Combination therapy with:	
4.2 Line of Therapy for CABOMETYX® (cabozantinib) Prescrip ☐ First line ☐ Second or subsequent treatment 4.3 Medications and Allergies Previous medications for diagnosis:	Drug allergies:
5 PRESCRIBER INFORMATION	REQUIRED
Prescriber name:	Practice name:

Please see full $\underline{\textbf{Prescribing Information}}$ for CABOMETYX.





Fax Completed and Signed Form to:



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





EASE ENROLLMENT FORM (CONT'D)



Patient last name:	First name:	DOB:/	REQUIRED
6 PRESCRIPTION	FOR 30-DAY FREE TRIAL PR	ROGRAM* (Limited to NEW patien	ts with on-label indication only)
Required for Please confir	m patient is newly prescribed CABON	METYX® (cabozantinib) 🗌 Yes 🔲 No	REQUIRE
CABOMETYX dose ☐ 60 mg ☐ 40 mg ☐ 20 n	Directions ang QD broad Other:	Quantity ☐ 30 tablets (per program guidelines)	Authorize refill 1 refill (limited to 1 refill for 5 day payer delay only)
MPORTANT: Please tell the patie		free 30-day supply of CABOMETYX will be our macy to obtain consent to ship the prescript state's prescription laws.	
☐ Dispense Prescriber fu	ll signature:		Date:/
7 PRESCRIPTION	FOR PAP* OR TRIAGE TO IN-	-NETWORK SPECIALTY PHAI	RMACY
IMPORTANT: In order for us to ser CABOMETYX dose ☐ 60 mg ☐ 40 mg ☐ 20 n	Directions	Quantity 30 tablets tablets	Authorize refills
– Please attach a separate prescrip	tion if this section does not comply with you	r state's prescription laws.	
8 PRESCRIPTION In-office dispensing (IOD) IOD contact's name:	FULFILLMENT pharmacy-prefer to dispense through	h an IOD pharmacy if possible	
		ion to the contracted or payer-mandat	
		owing pharmacy:	_
9 PRESCRIBER D	ECLARATION		REQUIRE
I have prescribed CABOMETYX® be authorization from the patient to t so that they may (1) contact the paverification and (3) determine patipharmacy on behalf of myself and submission of claims to any gover provided to me for the patient will	ased on my judgment of medical necessity ransmit the patient's personal health inforr tient at the patient's phone number(s) provent eligibility for the EXELIXIS product prog the patient. I understand that neither I nornment program or third-party insurer for a be provided to the patient for his or her ow	nined in this enrollment form is complete an and I will be supervising the patient's treatmention, as provided on this form, to EXELIXIS rided on this form and (2) perform a prelimin ram(s). I authorize the forwarding of this protect the patient may seek reimbursement from, any free product received under the program nuse without charge and I will not sell, reserved.	nent. I have received the necessary legal 5°, and parties working with EXELIXIS, hary assessment of insurance escription to a dispensing specialty submit claims to, or cause the (s). If applicable, any free producted, or attempt to resell such product.
Sign Here Prescriber fu	ll signature:	Da	te://
dditional restrictions and eligibility ru ease see full <u>Prescribing In</u>	les apply. formation for CABOMETYX.		
		Fax Completed and Signed Form	to:
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	VISIT: www.EAS

(1-844-901-3273)

