EASE EXELIXIS ACCESS SERVICES®

Access. Assistance. Along the Journey.

CABOMETYX® (cabozantinib) tablets

KEY INFORMATION TO COMPLETE AND SUBMIT THE EASE ENROLLMENT FORM

SERVICES AVAILABLE THROUGH EASE

- **15-Day Free Trial Program:** provides a free trial to help new CABOMETYX patients start treatment quickly, regardless of insurance type. For patients with a payer decision delay of 5 days or more, up to three additional 15-day supplies are available*†
- **Co-Pay Program:** eligible, commercially insured patients may pay as little as $0 per month. Annual and transaction limits apply‡
- **Patient Assistance Program (PAP):** eligible patients who cannot afford their drug costs may receive CABOMETYX free of charge†
- **Financial Assistance Information:** EASE can provide information regarding other financial assistance resources, if applicable
- **Benefits investigation:** EASE can investigate the patient's insurance coverage and payer requirements
- **Prior authorization/appeals support:** EASE can provide information on prior authorization requirements, along with applicable appeals processes, policies, 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

- ☐ Ensure **all required sections** of the form are **completed and signed**
- ☐ 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 15-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

*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.
§Patients are required to return any unused product.

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

Only patients, their authorized caregivers, or health care professionals can apply, submit, and/or engage with EASE.

EASE ENROLLMENT FORM

EASE EXELIXIS ACCESS SERVICES®

CABOMETYX® (cabozantinib) tablets

1 REQUESTED SERVICES *(Check all that apply)*

REQUIRED

- ☐ 15-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: _____

Date of birth: _____ /_____ /_____

☐ Male ☐ Female ☐ Non-binary ☐ Do not wish to disclose

Street address: _____

City: _____ State: _____ ZIP: _____

Home phone: _____

Cell phone: _____

Email: _____

Preferred contact method: ☐ Home phone ☐ Cell phone

Alternate contact name: _____

Relationship to patient: _____

Alternate phone: _____ ☐ Home phone ☐ Cell phone

Alternate email: _____

☐ OK to leave message with alternate contact

3 PATIENT INSURANCE INFORMATION *(Please include copy of front and back of insurance card[s])*

REQUIRED

3.1 Primary Medical Insurance Information

☐ Commercial ☐ Medicare ☐ Other Government Program (e.g., Medicaid, VA, TRICARE)

☐ Uninsured

Plan name: _____

Policy #: _____ Group #: _____

Phone: _____

Policyholder name: _____

Relationship to policyholder: _____

3.2 Prescription Drug Insurance Information

☐ Patient does not have prescription coverage

Company name: _____

Member #: _____ Group #: _____

PCN: _____ BIN: _____

Phone: _____

Policyholder name: _____

Relationship to policyholder: _____

Plan Sponsor (Employer): _____

4 PATIENT MEDICAL INFORMATION *(Please complete **all 3** sections – 4.1, 4.2, and 4.3)*

REQUIRED

4.1 Diagnosis

ICD-10 code: _____

☐ **Combination therapy with:** _____

4.2 Line of Therapy for CABOMETYX® (cabozantinib) Prescription

☐ First line ☐ Second or subsequent treatment

4.3 Medications and Allergies

Previous medications for diagnosis: _____

_____

Drug allergies: ☐ Yes ☐ No

If Yes, please list drug allergies: _____

5 PRESCRIBER INFORMATION

REQUIRED

Prescriber name: _____

Street address: _____

City: _____ State: _____

ZIP: _____

Phone: _____

Fax: _____

State license #: _____

NPI #: _____

Practice name: _____

Specialty: _____

Office contact's name: _____

Office contact's phone: _____

Office contact's email: _____

Group NPI #: _____

Tax ID #: _____

*Additional restrictions and eligibility rules apply.

Please see full Prescribing Information for CABOMETYX.

Fax Completed and Signed Form to:

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(1-844-901-3273)

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EASE ENROLLMENT FORM (CONT'D)

CABOMETYX® (cabozantinib) tablets

Patient last name: _____ **First name:** _____ **DOB:** ____ /____ /_____ REQUIRED

6 PRESCRIPTION FOR 15-DAY FREE TRIAL PROGRAM* *(Limited to NEW patients with on-label indication only)*

Required for Free Trial

Please confirm patient is newly prescribed CABOMETYX® (cabozantinib) ☐ **Yes** ☐ **No** REQUIRED

CABOMETYX dose	**Directions**	**Quantity**	**Authorize refill**
☐ **60** mg ☐ **40** mg ☐ **20** mg	☐ QD ☐ Other: _____	☐ **15** tablets (per program guidelines)	☐ 3 refills (limited to 3 refills for **5 day payer delay only**)

Complete this section and prescription for the 15-Day Free Trial Program. A free 15-day supply of CABOMETYX will be dispensed and shipped to the patient.
IMPORTANT: Please tell the patient to expect a call from **CoverMyMeds 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 TRIAGE TO IN-NETWORK SPECIALTY PHARMACY

IMPORTANT: *In order for us to send medication to your patient, the prescription information below must be complete and accurate.*

CABOMETYX dose	**Directions**	**Quantity**	**Authorize refills**
☐ **60** mg ☐ **40** mg ☐ **20** mg	☐ QD ☐ Other: _____	☐ **30** tablets ☐ ____ tablets	☐ _____ refills

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

Sign Here

Please check 1 box and sign on the line above it.
Prescriber full signature: _____ _____ **Date:** ____ /____ /_____
☐ **Dispense as written** ☐ **Substitution allowed**

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.

8 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: _____

9 PRESCRIBER DECLARATION

REQUIRED

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:** _____ /_____ /_____

*Additional restrictions and eligibility rules apply.

Please see full Prescribing Information for CABOMETYX.

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