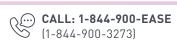


## **ENROLLMENT FORM**





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





REQUIRED Patient's last name:	First name:DOB: /
BY COMPLETING THIS FORM, I request the f	ollowing services on behalf of the patient:
☐ Forward prescription to in-network specialty pharmacy (SP)	☐ Patient Assistance Program (PAP) only
2 PATIENT INFORMATION	
Street address:	Alternate contact name:
City:State:	Relationship:
ZIP:	Alternate phone:
Home phone:	Cell phone:
Cell phone:	Alternate email address:
Email address:	$\square$ OK to leave message with alternate contact
3 INSURANCE INFORMATION NOTE: Please inclu	de copy of front and back of insurance card.
Primary Medical Insurance Information	Prescription Drug Insurance Information
☐ Commercial ☐ Medicare ☐ Uninsured	☐ Patient does not have prescription coverage.
Copy of insurance cards attached?	Rx insurance company name:
☐ Yes ☐ No	Rx member ID #:
Primary insurance (PI) company name:	Rx phone #:
PI policy #:	PCN:
PI group #:	BIN:
PI phone #:	Rx group #:
Policyholder name:	Rx policyholder name:
	Relationship to policyholder:
4 MEDICAL INFORMATION	
Patient Diagnosis (ICD-10-CM)	Current medications:
Medullary thyroid carcinoma (MTC)	
☐ C73 Malignant neoplasm of thyroid gland	Drug and non-drug allergies:
Other  □	
	☐ No known drug allergies
Diagnosis date:///	

Additional restrictions and eligibility rules apply.





Patient's last name:		First name: [	DOB:/	
5 PRESCRIBER INFORMATION				
Prescriber's name:		Office name:		
Street address:		Specialty:	Specialty:	
City:		Office contact's name:	Office contact's name:	
State: ZIP:		Office contact's phone:	Office contact's phone:	
Phone:		Office contact's email:	Office contact's email:	
Fax:			Group NPI #:	
State license #:			Tax ID #:	
Prescriber's NPI #:				
6 COMETRIQ PRESCRIPTION (Complete ONLY IF you need the prescription triaged to a specialty pharmacy or PAP.)				
In order for us to send medication to your patient, the prescription information below must be complete and accurate.				
COMETRIQ dose	Directions	Days' supply	Authorize refills	
☐ <b>140</b> mg ☐ <b>100</b> mg ☐ <b>60</b> mg	Daily	☐ 28 days' supply ☐ Other	refills	
Please attach a separate prescription if this section does not comply with your state's prescription laws.				
Please check 1 box and sign on the line above it.				
Sign Here Prescriber's full signature:		swritten	Date://	
'				
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.				
7 PRESCRIBER DECLARATION				
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				
COMETRIQ® 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				
determine patient eligibility for the EXELIXIS product program. 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 for any free product received under the program.				
Please attach a separate prescription if this form does not comply with your state's prescription laws.				
Sign Here Prescriber's full signatur	e:		Date: //	

CALL: 1-844-900-EASE Monday to Friday (1-844-900-3273) 8:00 AM to 8:00 PM



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

Fax Completed and Signed Form to:



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



VISIT: www.cometriq.com/hcp/access

Please see full Prescribing Information for COMETRIQ.



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