EASE EXELIXIS ACCESS SERVICES® ENROLLMENT FORM

COMETRIQ® (cabozantinib) 80 mg and 20 mg capsules

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.cometriq.com/hcp/access**

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

1 BY COMPLETING THIS FORM, I request the following services on behalf of the patient:

☐ Forward prescription to in-network specialty pharmacy (SP)

☐ Patient Assistance Program (PAP) only

2 PATIENT INFORMATION

Street address: _____

City: _____ State: _____

ZIP: _____ ☐ Male ☐ Female

Home phone: _____

Cell phone: _____

Email address: _____

Alternate contact name: _____

Relationship: _____

Alternate phone: _____

Cell phone: _____

Alternate email address: _____

☐ OK to leave message with alternate contact

3 INSURANCE INFORMATION *NOTE: Please include copy of front and back of insurance card.*

Primary Medical Insurance Information

☐ Commercial ☐ Medicare ☐ Uninsured

Copy of insurance cards attached?

☐ Yes ☐ No

Primary insurance (PI) company name:

_____

PI policy #: _____

PI group #: _____

PI phone #: _____

Policyholder name: _____

Prescription Drug Insurance Information

☐ Patient does not have prescription coverage.

Rx insurance company name: _____

Rx member ID #: _____

Rx phone #: _____

PCN: _____

BIN: _____

Rx group #: _____

Rx policyholder name: _____

Relationship to policyholder: _____

4 MEDICAL INFORMATION

Patient Diagnosis (ICD-10-CM)

Medullary thyroid carcinoma (MTC)

☐ C73 Malignant neoplasm of thyroid gland

Other

☐ _____

_____

Diagnosis date: _____/_____/_____

Current medications: _____

_____

Drug and non-drug allergies:

_____

_____

☐ No known drug allergies

Additional restrictions and eligibility rules apply.

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ENROLLMENT FORM

COMETRIQ® (cabozantinib) 80 mg and 20 mg capsules

REQUIRED **Patient's last name:** _____ **First name:** _____ **DOB:** _____/_____/_____

5 PRESCRIBER INFORMATION

Prescriber's name: _____
Street address: _____
City: _____
State: _____ ZIP: _____
Phone: _____
Fax: _____
State license #: _____
Prescriber's NPI #: _____

Office name: _____
Specialty: _____
Office contact's name: _____
Office contact's phone: _____
Office contact's email: _____
Group NPI #: _____
Tax ID #: _____

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
☐ **140** mg ☐ **100** mg ☐ **60** 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:** _____ _____ **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.

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 signature:** _____ **Date:** ___/___/_____

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Fax Completed and Signed Form to:
FAX: 1-844-901-EASE (1-844-901-3273)

VISIT: www.cometriq.com/hcp/access

Please see full Prescribing Information for COMETRIQ.