# 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 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 ☐ Non-binary ☐ Do not wish to disclose

Home phone: _____ Cell phone: _____

Preferred contact method: ☐ Home phone ☐ Cell phone

Email: _____

Alternate contact name: _____

Relationship to patient: _____

Alternate phone: _____

Alternate phone method: ☐ Home phone ☐ Cell phone

Alternate email: _____

☐ OK to leave message with alternate contact

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

### 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)*

### 4.1 Diagnosis

ICD-10 code: _____

### 4.2 Line of Therapy for COMETRIQ® (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: _____

_____

Additional restrictions and eligibility rules apply.

# EASE EXELIXIS ACCESS SERVICES® ENROLLMENT FORM

COMETRIQ® (cabozantinib) 80 mg and 20 mg capsules

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

## 5 PRESCRIBER INFORMATION

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 #: _____

## 6 COMETRIQ PRESCRIPTION *(Complete ONLY IF you need the prescription triaged to a specialty pharmacy or PAP)*

***IMPORTANT:*** *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 | ☐ QD ☐ Other_____ | ☐ **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 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

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 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 (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:** ____/____/_____

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

**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.**