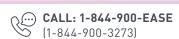
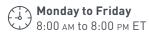


ENROLLMENT FORM











REQUIRED Patient last name:	First name:DOB: /
BY COMPLETING THIS FORM, I request the fo	ollowing services on behalf of the patient:
\square Forward prescription to in-network specialty pharmacy (SP)	☐ Patient Assistance Program (PAP) only
2 PATIENT INFORMATION	
Street address:	Alternate contact name:
4.1 Diagnosis ICD-10 code:	plete all 3 sections - 4.1, 4.2, and 4.3)
4.2 Line of Therapy for COMETRIQ® (cabozantinib) Prescription ☐ First line ☐ Second or subsequent treatment	
4.3 Medications and Allergies	Drug ellersies DVss DNs
Previous medications for diagnosis:	Drug allergies: ☐ Yes ☐ No If Yes, please list drug allergies:





REQUIRED Patient last name:		First name:D0	DB:/	
5 PRESCRIBER INFOR	MATION			
Prescriber name:		Practice name:		
Street address:		Specialty:		
City:		Office contact's name:		
State:	ZIP:	Office contact's phone:		
Phone:		Office contact's email:		
Fax:		Group NPI #:		
State license #:		Tax ID #:		
NPI #:				
6 COMETRIQ PRESCRI	PTION (Complete ONLY IF yo	u need the prescription triaged to a specia	alty 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 signa	ature:		Date:/	

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



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.cometrig.com/hcp/access

Please see full Prescribing Information for COMETRIQ.

