

KEY INFORMATION TO COMPLETE AND SUBMIT THE EASE ENROLLMENT FORM

SERVICES AVAILABLE THROUGH EASE

- ✓ **30-Day Free Trial Program:** provides a free trial to help new CABOMETYX patients start treatment quickly, regardless of insurance type, with a 30-day additional supply available for patients with a payer decision delay of 5 days or more**
- ✓ **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)
- Instruct patients to expect a call from RxCrossroads Specialty Pharmacy if the 30-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 *Cost & Financial Support* tab at www.cabometryx.com 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.cabometryxhcp.com/resources 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.

1	REQUESTED SERVICES <i>(Check all that apply)</i>	REQUIRED
<input type="checkbox"/> 30-Day Free Trial Program* <input type="checkbox"/> Patient Assistance Program (PAP)* <input type="checkbox"/> Benefits Investigation <input type="checkbox"/> Prior Authorization/Appeals Assistance <input type="checkbox"/> Prescription Triage to In-Network Specialty Pharmacy		

2	PATIENT INFORMATION	REQUIRED
Patient name: _____ Date of birth: ____/____/____ <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Do not wish to disclose Street address: _____ City: _____ State: _____ ZIP: _____ Home phone: _____ Cell phone: _____ Email: _____		
Preferred contact method: <input type="checkbox"/> Home phone <input type="checkbox"/> Cell phone Alternate contact name: _____ Relationship to patient: _____ Alternate phone: _____ <input type="checkbox"/> Home phone <input type="checkbox"/> Cell phone Alternate email: _____ <input type="checkbox"/> OK to leave message with alternate contact		

3	PATIENT INSURANCE INFORMATION <i>(Please include copy of front and back of insurance card[s])</i>	REQUIRED
3.1 Primary Medical Insurance Information <input type="checkbox"/> Commercial <input type="checkbox"/> Medicare <input type="checkbox"/> Other Government Program <input type="checkbox"/> Uninsured (e.g., Medicaid, VA, TRICARE) Plan name: _____ Policy #: _____ Group #: _____ Phone: _____ Policyholder name: _____ Relationship to policyholder: _____	3.2 Prescription Drug Insurance Information <input type="checkbox"/> Patient does not have prescription coverage Company name: _____ Member #: _____ Group #: _____ PCN: _____ BIN: _____ Phone: _____ Policyholder name: _____ Relationship to policyholder: _____	

4	PATIENT MEDICAL INFORMATION <i>(Please complete all 3 sections – 4.1, 4.2, and 4.3)</i>	REQUIRED
4.1 Diagnosis		
Renal cell carcinoma (RCC) <input type="checkbox"/> C64 Malignant neoplasm of kidney, except renal pelvis <input type="checkbox"/> C64.1 Malignant neoplasm of right kidney, except renal pelvis <input type="checkbox"/> C64.2 Malignant neoplasm of left kidney, except renal pelvis <input type="checkbox"/> C64.9 Malignant neoplasm of unspecified kidney, except renal pelvis <input type="checkbox"/> Combination therapy with nivolumab	Hepatocellular carcinoma (HCC) <input type="checkbox"/> C22.0 Liver cell carcinoma <input type="checkbox"/> C22.8 Malignant neoplasm of liver, primary, unspecified as to type Differentiated thyroid carcinoma (DTC) <input type="checkbox"/> C73 Malignant neoplasm of thyroid gland Other diagnosis and ICD-10 code <input type="checkbox"/> _____	
4.2 Line of Therapy for CABOMETYX® (cabozantinib) Prescription		
<input type="checkbox"/> First line <input type="checkbox"/> Second or subsequent treatment		
4.3 Current Medications and Allergies		
Current medications for selected diagnosis: _____ Drug and/or nondrug allergies: <input type="checkbox"/> Yes <input type="checkbox"/> 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:

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

CALL: 1-844-900-EASE
(1-844-900-3273)

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

VISIT: www.EASE.US

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



6 PRESCRIPTION FOR 30-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

CABOMETYX dose <input type="checkbox"/> 60 mg tablets <input type="checkbox"/> 40 mg tablets <input type="checkbox"/> 20 mg tablets	Directions Once daily	Quantity <input type="checkbox"/> 30 tablets (per program guidelines)	Authorize refill <input type="checkbox"/> 1 refill (limited to 1 refill for 5 day payer delay only)
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Complete prescription for the 30-Day Free Trial Program. A free 30-day supply of CABOMETYX will be dispensed and shipped to the patient.
IMPORTANT: Please tell the patient to expect a call from **RxCrossroads Specialty 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 <input type="checkbox"/> 60 mg tablets <input type="checkbox"/> 40 mg tablets <input type="checkbox"/> 20 mg tablets	Directions Once daily	Quantity <input type="checkbox"/> 30 tablets <input type="checkbox"/> ____ tablets	Authorize refills <input type="checkbox"/> _____ refills
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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.

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



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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