**PATIENT SHOULD COMPLETE these sections as needed:**

**SECTION 1:** Complete to use EASE services. **REQUIRED**

**NOTE TO PROVIDERS:**

EASE Patient Authorization form is required for specialty pharmacy (SP) referrals and EASE Patient Assistance Program (PAP) applications. EASE can assist with patient authorization if needed.

**SECTION 2:** Complete **ONLY IF** you would like to apply for the EASE Co-pay Program.

**SECTION 3:** Complete **ONLY IF** you would like to apply for the EASE PAP.

If you have any questions about completing this form, please contact EASE at 1-844-900-EASE (1-844-900-3273).

Fax page 2 of the completed form to 1-844-901-EASE (1-844-901-3273).
EASE PATIENT AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION: EASE

By signing below, I authorize Exelixis, Inc. (Exelixis) and its representatives, agents, and contractors, including the EASE Program operated by McKesson Specialty Arizona on behalf of Exelixis and other specialty pharmacies contracted with Exelixis [collectively, the Entities] to use and share among themselves my personal health information relevant to my treatment with Exelixis products [my PHI] for purposes of [1] providing the services offered by EASE [the program]; [2] undertaking financial support services, including benefits verification, potential out-of-pocket costs, and eligibility for financial assistance; [3] to see if I qualify for patient assistance; [4] facilitating the dispensing of medication, supplies, or services by Exelixis; [5] providing product support and services; [6] undertaking other online support, education, and assistance services; [7] enabling Exelixis and its agents to provide me with information, including promotional and product materials, regarding offers, services, and programs, educational training and ongoing support on the use of Exelixis products that may be of interest to me, and to contact me by mail, e-mail, or telephone to discuss Exelixis products and obtain feedback [for market research purposes]. I understand that once my PHI is shared with certain Entities as described above, it may not remain protected by federal privacy law and could be disclosed to others. I understand that pharmacies may receive payment for the use and disclosure of my PHI as described in this authorization. I further authorize pharmacies to use my PHI to communicate with me about the medicinal product that has been prescribed for me and that they may receive a fee for such communication.

I understand that I may refuse to sign this authorization and that if I do refuse, that it would not affect my rights to treatment or health benefits, but it would prevent me from enrolling in the EASE program. I also understand that I may cancel this authorization at any time by writing to EASE Access Services, PO BOX 52051, Phoenix, AZ 85072-2051 and requesting such cancellation, but that any such cancellation will not affect the sharing and use of my PHI by the Entities before they actually receive notice of my cancellation. If I do not cancel this authorization earlier, it will remain valid for 5 years from the date of my signature below. I understand that I have a right to receive a copy of this authorization when it is signed.

Please sign

Patient or Representative Name (Print):

Patient or Representative Signature: Date: ______ / ______ / ______

EASE CO-PAY PROGRAM FOR COMMERCIALLY INSURED PATIENTS

(Complete ONLY IF you want to apply for the EASE Co-Pay Program.)

I authorize EASE to enroll me in the Co-Pay Assistance Program and to use my personally identifiable information related to my therapy for program administration. By signing below, I acknowledge and attest that I do not participate in any Medicaid, Medicare, or similar federal, state, or other government-funded benefit programs. I understand that personal information being provided and information pertaining to the use of the EASE Co-Pay Assistance Program at the pharmacy, such as the date the transaction was processed and the amount of co-pay that will be paid for by Exelixis, Inc., will be shared with Exelixis, Inc., the sponsor of the program, and its third parties.

Please sign

I do not participate in any Medicaid, Medicare, or similar federal, state, or other government-funded benefit programs.

Patient or Representative Name (Print):

Patient or Representative Signature: Date: ______ / ______ / ______

EASE PATIENT ASSISTANCE PROGRAM (PAP) FOR UNINSURED/UNDERINSURED PATIENTS

(Complete ONLY IF you want to apply for the EASE Patient Assistance Program.)

I understand that I am providing “written instructions” authorizing EASE Patient Assistance Program, Exelixis and its vendor, under the Fair Credit Reporting Act ("FCRA"), to obtain information from my credit profile or other information from Experian Health, for the purpose of determining financial qualifications for programs administered by EASE. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process. I promise that any information, including financial and insurance information that I provide, are complete and true. If my income or health coverage changes, I will call EASE at 844-900-3273. If eligible, I would like to be considered for programs administered by EASE.

Income limits apply. This information will only be used to determine eligibility for PAP. PAP applicants may be required to submit verification for all sources of household income. No party may seek reimbursement for any free drug provided to the patient under the EASE PAP. Free drug (1) may not count toward a patient’s out-of-pocket costs under their insurance plan, such as the true-out-of-pocket (TrOOP) under Medicare Part D and (2) is not contingent on any purchase.

Please sign

Social Security Number: ________ Annual Pre-tax Household Income: ________ Number of Family Members Living in Household: ______

Please Check All That Apply:

☐ Resident of the United States, Puerto Rico, Guam, or US Virgin Islands
☐ No prescription coverage, or not enough coverage to pay for your Exelixis medicine

Patient or Representative Name (Print):

Patient or Representative Signature: Date: ______ / ______ / ______