15-DAY FREE TRIAL PROGRAM

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)

Patient's Last Name: ______________ **First Name:** ______________ **DOB:** ____/____/____

1 PATIENT CONTACT

REQUIRED

Street address: ______________
City: ______________ State: ______________
ZIP: ______________ ☐ Male ☐ Female
Home phone: ______________
Cell phone: ______________
Email address: ______________

Alternate contact's name: ______________
Relationship: ______________
Alternate contact's phone: ______________
Alternate contact's cell phone: ______________
Alternate contact's email address: ______________
☐ OK to leave message with alternate contact

☐ **I request contact from EXELIXIS Access Services® (EASE) for additional services for this patient.**

2 MEDICAL INFORMATION

NOTE: Please complete sections 2.1 through 2.3 regarding your patient's diagnosis

REQUIRED

2.1 Diagnosis

Renal cell carcinoma (RCC)

☐ **C64** Malignant neoplasm of kidney, except renal pelvis
☐ **C64.1** Malignant neoplasm of right kidney, except renal pelvis
☐ **C64.2** Malignant neoplasm of left kidney, except renal pelvis
☐ **C64.9** Malignant neoplasm of unspecified kidney, except renal pelvis

☐ **Combination Therapy with Nivolumab**

Hepatocellular carcinoma (HCC)

☐ **C22.0** Liver cell carcinoma
☐ **C22.8** Malignant neoplasm of liver, primary, unspecified as to type

Differentiated thyroid carcinoma (DTC)

☐ **C73** Malignant neoplasm of thyroid gland

Other diagnosis and ICD-10 code

☐ ______________

2.2 Line of therapy for CABOMETYX® (cabozantinib) prescription

☐ First-line treatment ☐ Second-line or subsequent treatment

2.3 Current medications and allergies for selected diagnosis

Current medications: ______________

Drug and non-drug allergies: ☐ Yes ☐ No
If Yes, please list drug allergies: ______________

3 PRESCRIBER INFORMATION AND DECLARATION

REQUIRED

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

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

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 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 this medication is complimentary, provided at no cost, and that neither I nor the patient may seek reimbursement for any free product received under the program. Please attach a separate prescription if this section does not comply with your state's prescription laws.

Sign Here **Prescriber's full signature:** ______________ **Date:** ____/____/____

4 PRESCRIPTION FOR CABOMETYX: 15-DAY FREE TRIAL PROGRAM*

REQUIRED

(15-Day Free Trial limited to NEW patients with on-label indications only)

Please confirm patient is newly prescribed CABOMETYX ☐ **Yes** ☐ **No**
Complete prescription for the 15-day Free Trial Program. A free 15-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 his or her consent to ship.

CABOMETYX dose	**Directions**	**Quantity**
☐ **60** mg ☐ **40** mg ☐ **20** mg	Once daily	☐ 15 tablets (per program guidelines)

Please attach a separate prescription if this section does not comply with your state's prescription laws.

Sign Here ☐ **Dispense as written**
Prescriber's full signature: ______________ **Date:** ____/____/____

*Additional restrictions and eligibility rules apply.

Please see full Prescribing Information for CABOMETYX.

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