In multiple myeloma, outcomes are poor for patients who are recycled on an anti-CD38 mAb[1]

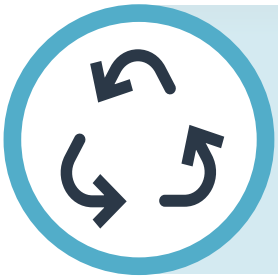
>70% Exposed to Anti-CD38 mAb by 2L

According to Komodo claims data from 2022,
Over 30% of patients were exposed to an anti-CD38 mAb-based regimen in 1L, and over 70% of patients were exposed after receiving their 2L treatment[2]

Poor Outcomes Once Refractory

In MAMMOTH*, a retrospective analysis of 275 patients refractory to an anti-CD38 mAb,
31% of patients refractory to an anti-CD38 mAb responded to their next therapy, with mPFS of 3.4 months and mOS of 9.3 months[3]

Poor Outcomes With Recycling



According to a prospective analysis of 32 patients refractory to an anti-CD38 mAb,
Recycling an anti-CD38 mAb-based regimen in the next line of therapy resulted in an ORR of 0%, mPFS of 1.6 months, and mOS of 10.7 months[1]

In a retrospective cohort study of 1118 patients exposed to >1 line of therapy,
For nearly half of patients, an anti-CD38 mAb-based regimen was recycled in their next line of therapy[4]

*Data collected between January 2017 and June 2018. Among the subgroup of 249 patients who received ≥ 1 subsequent treatment beyond time zero (T_0) were analyzed using comparisons of PFS and OS estimates. T_0 was the time point when patients met the criteria of progression as defined by the IMWG Response Criteria.

Patients are in need of novel treatment options once refractory to an anti-CD38 mAb[3,5]

The NCCN Recommends Against Recycling Anti-CD38 mAbs Once Refractory*

The National Comprehensive Cancer Network® (NCCN®) suggests regimens without anti-CD38 be considered for those refractory to anti-CD38 antibody as long as they have not received or are refractory to other agents in the regimen[6]

The NCCN Recommends Introducing Different Drugs/Drug Therapies

For early relapse (1-3 prior therapies) in MM, the NCCN recommends that an attempt should be made to use drugs/drug classes the patients have not been exposed to or exposed to >1 line prior[6]

Different Drug Classes are Limited

Treatment options that introduce a different drug class are limited in early lines of therapy after exposure to an anti-CD38 mAb-based regimen[7, 8]

*NCCN makes no warranties of any kind whatsoever regarding their content, use, or application and disclaims any responsibility for their application use in any way.

Consider XPOVIO, a different treatment class for patients who relapse, including those who have been exposed to an anti-CD38 mAb-based regimen[9]

XPOVIO® (selinexor)

LINES OF THERAPY IN MM

Select presentation – not intended to be comprehensive.

XVd is a NCCN Preferred Category 1* Regimen in Early RRMM[6†]

Oral, once weekly selinexor (XPOVIO®) in combination with bortezomib and dexamethasone (XVd) is recommended by the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) as a **preferred NCCN Category 1*** therapeutic option in previously treated (1–3 prior lines), lenalidomide-refractory MM.

*Category 1: Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.

†NCCN makes no warranties of any kind whatsoever regarding their content, use, or application and disclaims any responsibility for their application or use in any way.

XPOVIO – The fastest growing brand in 3L MM in 2021 and 2022[2]

Based on Komodo claims analysis comparing U.S. XPOVIO market share in new patients vs. available brands approved in 3L MM in FY 2021 and 2022.

INDICATION

XPOVIO® (selinexor) is a prescription medicine approved in combination with bortezomib and dexamethasone (XVd) to treat adult patients with multiple myeloma (MM) who have received at least one prior therapy.

IMPORTANT SAFETY INFORMATION

Thrombocytopenia: XPOVIO can cause life-threatening thrombocytopenia, potentially leading to hemorrhage. Thrombocytopenia was reported in patients with multiple myeloma (MM) and developed or worsened in patients with DLBCL.

Thrombocytopenia is the leading cause of dosage modifications. Monitor platelet counts at baseline and throughout treatment. Monitor more frequently during the first 3 months of treatment. Monitor patients for signs and symptoms of bleeding. Interrupt, reduce dose, or permanently discontinue based on severity of adverse reaction.

Please see Important Safety Information on the next page, and accompanying full Prescribing Information.

IMPORTANT SAFETY INFORMATION (cont'd)

Neutropenia: XPOVIO can cause life-threatening neutropenia, potentially increasing the risk of infection.

Monitor more frequently during the first 3 months of treatment. Consider supportive measures, including antimicrobials and growth factors (e.g., G-CSF). Interrupt, reduce dose, or permanently discontinue based on severity of adverse reaction.

Gastrointestinal Toxicity: XPOVIO can cause severe gastrointestinal toxicities in patients.

Nausea/Vomiting/Diarrhea: Provide prophylactic antiemetics or treatment as needed.

Anorexia/Weight Loss: Monitor weight, nutritional status, and volume status at baseline and throughout treatment and provide nutritional support, fluids, and electrolyte repletion as clinically indicated.

Hyponatremia: XPOVIO can cause severe or life-threatening hyponatremia. Monitor sodium level at baseline and throughout treatment.

Serious Infection: XPOVIO can cause serious and fatal infections. Atypical infections reported after taking XPOVIO include, but are not limited to, fungal pneumonia and herpesvirus infection.

Neurological Toxicity: XPOVIO can cause life-threatening neurological toxicities.

Coadministration of XPOVIO with other products that cause dizziness or mental status changes may increase the risk of neurological toxicity.

Advise patients to refrain from driving and engaging in hazardous occupations or activities until the neurological toxicity fully resolves. Institute fall precautions as appropriate.

Embryo-Fetal Toxicity: XPOVIO can cause fetal harm when administered to a pregnant woman.

Advise pregnant women of the potential risk to a fetus. Advise females of reproductive potential and males with a female partner of reproductive potential to use effective contraception during treatment with XPOVIO and for 1 week after the last dose.

Cataracts: New onset or exacerbation of cataract has occurred during treatment with XPOVIO. The incidence of new onset or worsening cataract requiring clinical intervention was reported.

ADVERSE REACTIONS

The most common adverse reactions (ARs) (≥20%) in patients with multiple myeloma who received XVd were fatigue, nausea, decreased appetite, diarrhea, peripheral neuropathy, upper respiratory tract infection, decreased weight, cataract, and vomiting.

Grade 3–4 laboratory abnormalities (≥10%) were thrombocytopenia, lymphopenia, hypophosphatemia, anemia, hyponatremia and neutropenia.

Fatal ARs occurred in 6% of patients within 30 days of last treatment. Serious ARs occurred in 52% of patients. Treatment discontinuation rate due to ARs was 19%. The most frequent ARs requiring permanent discontinuation in >2% of patients included fatigue, nausea, thrombocytopenia, decreased appetite, peripheral neuropathy and vomiting. Adverse reactions led to XPOVIO dose interruption in 83% of patients and dose reduction in 64% of patients.

USE IN SPECIFIC POPULATIONS

No overall difference in effectiveness of XPOVIO was observed in patients >65 years old when compared with younger patients. Patients ≥65 years old had a higher incidence of discontinuation due to an adverse reaction (AR) and a higher incidence of serious ARs than younger patients. The effect of end-stage renal disease (CL_{CR} <15 mL/min) or hemodialysis on XPOVIO pharmacokinetics is unknown.

Please see Important Safety Information throughout this brochure, and accompanying full Prescribing Information.

To report SUSPECTED ADVERSE REACTIONS, contact Karyopharm Therapeutics Inc. at 1-888-209-9326 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

1L/2L/3L/4L, first/second/third/fourth-line; CAR-T, chimeric antigen receptor T cell therapy; CD38, cluster of differentiation 38; CICr, creatinine clearance; FDA, United States Food and Drug Administration; FY, fiscal year; G-CSF, granulocyte colony-stimulating factor; IMiD, immunomodulatory drug; IMWG, international myeloma working group; mAb, monoclonal antibody; MM, multiple myeloma; mOS, median overall survival; mPFS, median progression-free survival; NCCN, National Comprehensive Cancer Network; ORR, objective response rate; PI, proteasome inhibitor; RRMM, relapsed/refractory multiple myeloma; XPO1, exportin 1.

References: 1. Mikhael J, et al. *Blood Cancer*. 2021, 11(5):89; **2.** Data on File. Kayropharm Therapeutics Inc. 2022; **3.** Ghandi UH, et al. *Leukemia*. 2019;33(9):2266-2275; **4**. Richter J, et al. Poster presentation at ASH 2022, New Orleans, Louisiana, December 10-13, 2022 [poster 1891]; **5.** Dimopoulos MA, et al. *Clin Lymphoma Myeloma Leuk*. 2022;22(7):460-473; **6.** Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Multiple Myeloma v1.2024. ©National Comprehensive Cancer Network, Inc. 2023. All rights reserved. Accessed October 19, 2023. To view the most recent and complete version of the guideline, go to www.NCCN.org. NCCN makes no warranties of any kind whatsoever regarding their content, use, or application and disclaims any responsibility for their application or use in any way; **7.** REVLIMID® [prescribing information]. Summit, NJ: Bristol-Myers Squibb; **8.** VELCADE® [prescribing information]. Tokyo, Japan: Takeda Pharmaceuticals; **9.** XPOVIO® [prescribing information]. Newton, MA: Karyopharm Therapeutics Inc; **10.** TECVAYLI™ [prescribing information]. Beerse, Berlin: Janssen Biotech, Inc; **11.** EVOMELA® [prescribing information]. East Windsor, NJ: Acrotech Biopharma, Inc; **12.** ABECMA® [prescribing information]. Summit, NJ: Bristol-Myers Squibb.