KaryFORWARD®
PATIENT SUPPORT BY KARYOPHARM

KaryForward is a support program by Karyopharm dedicated to providing assistance and resources to patients and their caregivers for Karyopharm medications.

Karyopharm® Therapeutics

Enrollment Form

Please select from KaryForward Support Offered*

Please see the instructions on page 3 for a quick reference on how to fill out this form and enroll your patient in KaryForward.

Insurance Related Services:
- ☐ Benefit investigation, Prior Authorization, Appeal Assistance
- ☐ QuickStart Program
- ☐ Bridge Program

Financial Assistance
- ☐ XPOVIO® Copay Program
- ☐ Patient Assistance Program

Support and Resources
- ☐ KaryForward Nurse Support Program
- ☐ Independent third-party Copay Assistance

**All programs and support are subject to eligibility requirements.*

1. Healthcare Professional /Facility Information

Prescriber Name: _____ (first) _____ (last)

Prescriber Title: _____

NPI #: _____ DEA #: _____

Tax ID #: _____ PTAN #: _____

Facility Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Office Contact Name: _____

Office Contact Phone: _____

Fax #: _____

Office Contact Email: _____

2. Patient Information

Patient Name: _____

Sex: ☐ Male ☐ Female Date of Birth: _____ / _____ / _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Office

Best Time to Contact:
☐ DAY (8am - 5pm ET) ☐ Night (after 5pm ET)

Caregiver name/number: _____

3. Insurance Information

Patient is insured by (check all that apply):

☐ Medicare Part A (Hospital) ☐ Medicare Part B (Medical) ☐ Medicare Part D (Prescription) ☐ Medicare Advantage Medicare ID _____

☐ Medicaid ☐ VA or Military ☐ Commercial/Private Insurance ☐ State Assistance Program for Medication ☐ None ☐ Other _____

Insurance Name:	Phone #:	Member ID/Policy #:	Group #:	Policy Cardholder:	PCN #:
Primary Insurance					
Secondary Insurance					
Prescription Insurance					
Other Insurance					

Patient Assistance Program Eligibility Criteria: Annual family gross income (before taxes and deductions) must be equal to or less than 800% of the current Federal Poverty Level. Include at least one of the following documentations to verify household income:

- ☐ Current Federal Income Tax Return
- ☐ Social Security award letter for the current calendar year
- ☐ Unemployment letter or Notarized letter of financial hardship
- ☐ W-2 or 1099 forms

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4. Preferred Specialty Pharmacy (Select one):

☐ Biologics, Inc. ☐ Onco 360 ☐ US Bioservices ☐ In-office dispensing site ☐ No preference

5. Prescription Information *QuickStart for first prescription: ☐ Yes ☐ No*

Patient Name: _____ **Start Date:** ____ / ____ / ____

Rx for XPOVIO® (selinexor) Quantity: _____ Refills: _____

Directions for Use: Take _____ 20 mg tablets (total_____mg per dose) in combination with (if applicable)_____

on days _____ and _____ of each week. **Additional Directions:** _____

Prescriber Name: _____ Prescriber Signature _____ Date: ____ / ____ / ____

The prescribed quantity of XPOVIO (selinexor) will be shipped to the address indicated in Section 2 above.

6. Clinical Information

Patient Diagnosis: _____ ICD-10 Code _____ Date: ____ / ____ / ____

7. Healthcare Professional Certification and Patient Consent

By signing below, I hereby represent, covenant, and certify as follows: (1) The above therapy (or medicine) is medically necessary; (2) I have obtained from my patient his or her consent and any required written authorization as required by HIPAA and other federal or state laws to release to KaryForward (Karyopharm Therapeutics Patient Access and Support Services) and its representatives/agents all patient information needed for this application, including, without limitation, my patient's financial and medical information; (3) I understand this information is for the sole use of KaryForward and its representatives/agents to assess the patient's eligibility for participation in KaryForward including KaryForward Support Program; (4) I have not received, nor will I seek or accept reimbursement from any federal, state, or private payers for any drug provided for my patient by XPOVIO (selinexor) Patient Assistant Program (PAP); (5) I have not received, nor will I seek or accept payment from my patient for any co-insurance amount paid for by the XPOVIO Co-Pay Card Program for a Karyopharm Therapeutics product; (6) I understand that if my patient's insurance or financial status changes, the patient may no longer be eligible under this program. I will notify KaryForward if I become aware of any such changes; (7) I understand that I am under no obligation to prescribe any Karyopharm Therapeutics drug and I have not received and will not receive any benefit from Karyopharm Therapeutics for prescribing a Karyopharm Therapeutics drug;

Healthcare Professional Name _____

Healthcare Professional Signature (no stamps please) _____ **Date:** ____ / ____ / ____

I hereby authorize my healthcare professionals, my health insurance company, and my pharmacy to (1) disclose my protected health information (PHI) including, but not limited to, my name, address, telephone number, medical records, health insurance coverage, and financial information to KaryForward and its agents; (a) To contact me, or the person legally authorized to sign on my behalf, by phone or mail, (b) to contact my insurance company on my behalf to verify my coverage for XPOVIO (selinexor), (c) To determine my eligibility for enrollment in the XPOVIO Co-pay Card Program and for enrollment in the XPOVIO (selinexor) Patient Assistant Program (PAP), including verification of my financial information; (2) Recommend an independent third-party foundation for assistance or alternate sources of funding or coverage that may be available to provide assistance with out-of-pocket expenses; (3) Coordinate my treatment with my healthcare professionals and specialty pharmacy, and send me educational materials or other program information that may be of interest to me. (4) I understand the information provided by me, my healthcare professional, or insurance company may be used for marketing purposes. (5) Once my health information has been disclosed to KaryForward, I understand that federal privacy laws may no longer protect the information. (6) However, I understand that Karyopharm Therapeutics and other companies authorized to receive my health information pursuant to this Authorization agree to protect my health information by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations. (7) I understand this authorization does not affect treatment from my healthcare professional or coverage for XPOVIO (selinexor) through my insurance.

Patient Signature _____ **Date:** ____ / ____ / ____

Legal Representative Signature _____ **Date:** ____ / ____ / ____

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How to enroll in KaryForward:

1. Complete the first 2 pages of this form.
2. Healthcare Professional to sign and date Section 7 on page 2.
3. Patient to sign and date the Patient Consent Section 7 on page 2.
4 . Fax completed enrollment form to KaryForward at **1-833-589-1603**
5. Please complete form in its entirety to help prevent processing delay(s).

Instructions Guide

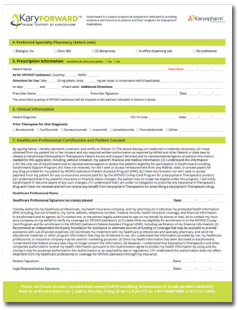

Enrollment Form

Select services requested to specify the needs of your patient.

Sections 1 and 2: Healthcare Professional and Patient contact information is required in this section. Be sure to include NPI and DEA numbers to help facilitate the Benefits Investigation.

Section 3: Be sure to fill out the patient's insurance information. In addition, a copy of both sides of the patient's insurance cards can be included at your discretion.

Section 4: Select your preferred specialty pharmacy. If your preferred specialty pharmacy is not in the KaryForward limited distribution network or honored by the patient's insurance plan, please select *No preference,* and the Enrollment form will be sent to the approved specialty pharmacy for dispensing.



Section 5: XPOVIO® (selinexor) QuickStart Prescription: Patients receiving their first XPOVIO (selinexor) prescription who cannot obtain coverage or verification of coverage within 5 business days may be eligible for this program. Please complete prescription information and check the XPOVIO (selinexor) QuickStart Prescription box if interested.

This section can serve as the prescription for XPOVIO (selinexor) for commercial patients. **Be sure to attach a separate prescription if this section does not comply with your state's prescription law.**

XPOVIO (selinexor) will be delivered to the patient's home unless otherwise requested in this section.

Section 6: Clinical information requested is very important and often requested when verifying benefits. Diagnosis and appropriate ICD-10 code are required fields.

Section 7: Requires a patient (or a legal representative) and a healthcare professional's signature. A healthcare professional's signature is required to attest to the review of the certification and consent.

Additional Resources: KaryForward Support Program: KaryForward is pleased to offer patients and caregivers an option to receive additional support from dedicated Nurse Case Managers. As part of the KaryForward support services, Nurse Case Managers can provide nonclinical education on their medication, review their prescribed dosing schedule, and educate them on what they may expect when taking their medication, based upon the full prescribing information.

Please see XPOVIO (selinexor) **Full Prescribing Information** at XPOVIOpro.com
Visit us at KaryForward.com | **Call** us Monday-Friday (8 am to 8 pm ET) at: **1-877-KARY4WD** (1-877-527-9493)