KaryFORWARD®
PATIENT SUPPORT BY KARYOPHARM

Enrolling Patients in KaryForward Patient Support

OPTION 1

To enroll patients online via Docusign, visit ***KaryForward.com/HCP***

OPTION 2

Complete this enclosed enrollment form. All fields are required. Incomplete fields may result in processing delays.

- ☐ Ensure all sections of the enrollment form are fully completed.
- ☐ If requesting a QuickStart, prescriber's signature/date is required in section 7.
- ☐ Prescriber's signature/date is required for prescription in Section 8.

If necessary please attach a separate prescription for sections 7 and 8 to meet your state's requirement.

- ☐ Prescriber's signature/date is required in Section 10.
- ☐ Patient or legal representative's signature/date is required in section 11. If patient is not present to sign consent section 11, they may use the e-consent form on ***KaryForward.com***
- ☐ If applying for the Patient Assistance Program, patient or legal representative's signature/date is required in section 12.
- ☐ If patient has insurance, if possible, include a copy of both sides of patient's insurance cards.

SUBMIT **FAX completed enrollment form to 1-833-589-1603**

Karyopharm® Therapeutics

KaryFORWARD®
PATIENT SUPPORT BY KARYOPHARM

Enrollment Form

Be sure to fill out all sections of this form. All fields are required. Incomplete fields may cause processing delays.

1 KaryForward Options* *(select any of interest)*

Insurance Verification

- ☐ Benefit Investigation, Prior Authorization, Appeal Assistance

Financial Assistance

- ☐ Patient Assistance Program (PAP)
- ☐ Copay Program

(patients may also be enrolled directly online at: **KaryForward.com/HCP**)

Support and Resources

- ☐ Nurse Case Manager
- ☐ Independent Third-Party Copay Assistance

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

2 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 Email: _____

Office Phone: _____ Fax: _____

3 Patient Information

Patient Name (first last): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Shipping Address: _____
(if different than mailing)

City: _____ State: _____ Zip: _____

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

Home Phone: _____ Cell Phone: _____

Email: _____

Preferred Contact: ☐ Home Phone ☐ Cell Phone ☐ Email

Best Time to Contact: ☐ Day (8am–5pm ET) ☐ Night (after 5pm ET)

4 Caregiver Information *(optional)*

Caregiver Name: _____

Contact Caregiver instead of Patient? ☐ Yes ☐ No

Caregiver Phone: _____

Best Time to Contact: ☐ Day (8am–5pm ET) ☐ Night (after 5pm ET)

5 Insurance Information *(if possible, please include a copy of both sides of patient's insurance cards)*

Patient is insured by: *(check all that apply)*

- ☐ Commercial/Private Insurance
- ☐ Medicare Part A (Hospital)
- ☐ Medicare Part B (Medical)
- ☐ Medicare Part D (Prescription)
- ☐ Medicare Advantage
- ☐ Medicaid
- ☐ VA or Military
- ☐ State Assistance Program for Medication
- ☐ Other: _____
- ☐ None

Medicare ID: _____

Primary Insurance

Provider: _____

Provider Phone: _____

Cardholder Name: _____

Member ID/Policy #: _____

Group #: _____

Prescription Insurance

Provider: _____

Provider Phone: _____

Cardholder Name: _____

Member ID/Policy #: _____

Rx BIN #: _____ Rx PCN #: _____

Be sure to fill out all sections of this form. All fields are required. Incomplete fields may cause processing delays.

6 Preferred Specialty Pharmacy *(select one)*

○ In-office dispensing site ○ Onco 360 ○ Biologics, Inc. ○ No preference

7 QuickStart Program *(optional – complete this section only for QuickStart prescription)*

If necessary please attach a separate prescription to meet your state's requirement.

Patient Name: _____ Date of Birth: ____ /____ /_____

Rx for XPOVIO® (selinexor)

Dose prescribed (mg weekly): _____

QTY of tablets (7 day supply): _____

See table in Section 8 for additional dose information

START DATE: ____ /____ /_____

NOTE: XPOVIO® (selinexor) will be delivered to the mailing address in Section 3 unless a different shipping address is provided.

Instructions: _____

Prescriber Name (print): _____

SIGN HERE Prescriber Signature: _____ Date: _____ /_____ /_____

8 PAP Prescription Information

If necessary please attach a separate prescription to meet your state's requirement.

Patient Name: _____ Date of Birth: ____ /____ /_____

Rx for XPOVIO® (selinexor)

	Weekly Dose *(select only one)*	**Tablets for 28 Day Supply**	**NDC**
○	100 mg once weekly	Two 50 mg tablets per blister pack (8 tablets per carton)	NDC 72237-103-05
○	80 mg once weekly	Two 40 mg tablets per blister pack (8 tablets per carton)	NDC 72237-102-02
○	60 mg once weekly	One 60 mg tablets per blister pack (4 tablets per carton)	NDC 72237-104-01
○	40 mg once weekly	One 40 mg tablets per blister pack (4 tablets per carton)	NDC 72237-102-07
○	80 mg twice weekly	Eight 20 mg tablets per blister pack (32 tablets per carton)	NDC 72237-101-04
○	60 mg twice weekly	Six 20 mg tablet per blister pack (24 tablets per carton)	NDC 72237-101-03
○	40 mg twice weekly	Two 20 mg tablet per blister pack (8 tablets per carton)	NDC 72237-102-06

START DATE: ____ /____ /_____

QTY of tablets (28 day supply): _____

Refills: _____

NOTE: XPOVIO® (selinexor) will be delivered to the mailing address in Section 3 unless a different shipping address is provided.

Additional instructions: _____

Prescriber Name (print): _____

SIGN HERE Prescriber Signature: _____ Date: _____ /_____ /_____

9 Clinical Information

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

Prior Treatment: _____ Current Line of Therapy: _____

XPOVIO Regimen/Combination: _____ Additional medications: _____

Be sure to fill out all sections of this form. All fields are required. Incomplete fields may cause processing delays.

10 Healthcare Professional Certification

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 that KaryForward and its representatives/agents will use this information to assess the patient's eligibility for participation in KaryForward;

(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 the Patient Assistance 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® Copay 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;

(8) the information contained in this form is complete and accurate to the best of my knowledge; and

(9) I will notify KaryForward of any errors regarding the foregoing, and will make every effort to correct those errors.

HCP Name (print): _____

SIGN HERE HCP Signature (no stamps please): _____ Date: _____ /_____ /_____

Be sure to fill out all sections of this form. All fields are required. Incomplete fields may cause processing delays.

*Patient e-consent in English is available online at **KaryForward.com**. You may also download patient consent forms for Spanish or Chinese speaking patients to replace sections 11 and 12. Return all completed pages of this enrollment form with signed patient consent.*

11 Patient Consent

I hereby authorize my healthcare professionals, my health insurance company, and my pharmacy to 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. I understand that once my health information has been disclosed to KaryForward, it could be subject to redisclosure and that federal privacy laws may no longer protect the information.

I hereby authorize KaryForward and its agents (1) To contact me, or the person legally authorized to sign on my behalf, by phone or mail, (2) to contact my insurance company on my behalf to verify my coverage for XPOVIO® (selinexor), (3) to determine my eligibility for enrollment in the XPOVIO® Copay Program and for enrollment in the Patient Assistance Program (PAP), including verification of my financial information, (4) to determine my eligibility for enrollment in the Dose Exchange Program, (5) Provide me with information regarding any independent third-party foundation or alternate sources of funding or coverage that may be available to provide assistance with out-of-pocket expenses, (6) Coordinate my treatment with my healthcare professionals and specialty pharmacy, and (7) Send me materials regarding products, services, or other information that may be of interest to me.

I understand that if I refuse to sign this authorization, it will not affect my treatment by my healthcare professionals, or my payment, enrollment, or eligibility for benefits from my health plan. However, if I refuse to sign this authorization, or sign and then withdraw my authorization at a later date, it may affect my ability to participate in KaryForward. If I do not withdraw authorization, it will remain valid for 3 years (or at such lesser time as state law may require). I understand I am entitled to receive a copy of this authorization.

Patient or Legal Representative Name (print):_____

SIGN HERE Patient or Legal Representative Signature:_____ Date: _____ /_____ /_____

12 Patient Financial Consent *(only required if applying for Patient Assistance Program)*

Gross Annual Household Income: _____ No. of household members dependent on income (include applicant): _____

Income source(s) (check all that apply): ☐ Job ☐ Family ☐ Public Assistance ☐ SSI/SSDI ☐ Other: _____

KaryForward may need additional documentation to assess program eligibility (i.e., 1040 Tax Return, SSA-1099, W-2 Form)

Patient Acknowledgment:

I understand that completing this form does not ensure my enrollment in the Patient Assistance Program ("PAP").

By signing below, I certify that the information provided is complete and accurate. I authorize Karyopharm and its service providers administering the PAP (collectively, "KaryForward") to obtain financial information from my credit profile or other financial information from Experian Income View. I understand that KaryForward needs, and I agree that KaryForward may use, this financial information to determine my financial eligibility to participate in KaryForward's Patient Assistance Program. I also agree to provide additional financial documentation in a timely manner, if so requested.

Patient or Legal Representative Name (print):_____

SIGN HERE Patient or Legal Representative Signature:_____ Date: _____ /_____ /_____