KaryForward™ Enrollment Form

Fax the completed enrollment form to:
1-833-589-1603

Call us Monday-Friday (8 am to 5 pm ET)
at: **1-877-KARY4WD (1-877-527-9493)**

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

Please check all services for which you are applying

- ❑ Insurance Related Services (Benefit investigation, Prior Authorization, and/or Appeal Assistance)
- ❑ Financial Assistance (XPOVIO™ Co-Pay Card Program, and independent third-party Co-Pay Assistance)
- ❑ XPOVIO™ (selinexor) Patient Assistance Program (PAP)
- ❑ KaryForward Support Program
- ❑ XPOVIO™ (selinexor) QuickStart
- ❑ XPOVIO™ (selinexor) Bridge
- ❑ Patient Educational Starter Kit
- ❑ Caregiver Educational Starter Kit

All services and programs are subject to eligibility requirements.

1. Healthcare Professional /Facility Information

Prescriber's Name: ______________________
first last

Prescriber's Title: ______________________

NPI #: ______________ DEA #: ______________

Tax ID #: ______________ PTAN #: ______________

Facility Name: ______________________

Mailing Address: ______________________

City: ______________ State: ______ Zip: ______

Office Contact's Name: ______________________

Office Contact's Title: ______________________

Office Contact's Phone #: ______________ Fax #: ______________

Office Contact's Email: ______________________

2. Patient Information

Patient's Name: ______________________
first last

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 ❑ Email

Best Time to Contact:
❑ AM (8 am to 10 am ET) ❑ DAY (10am to 5pm ET) ❑ PM (after 5pm ET)

Additional Contact: ______________________
first last phone

3. Insurance Information ❑ Uninsured

Primary Medical Insurance Payer: ______________________

Phone #: ______________________

Subscriber ID #: ______________ Group #: ______________

Subscriber Name: ______________________

Primary Pharmacy Benefit Manager (PBM): ______________________

PBM Name: ______________________

Phone #: ______________________

Insurance ID #: ______________ Group #: ______________

BIN: ______________ PCN: ______________

Secondary Medical Insurance Payer: ______________________

Phone #: ______________________

Subscriber ID #: ______________ Group #: ______________

Subscriber Name: ______________________

Secondary Pharmacy Benefit Manager (PBM): ______________________

PBM Name: ______________________

Phone #: ______________________

Insurance ID #: ______________ Group #: ______________

BIN: ______________ PCN: ______________

4. Preferred Specialty Pharmacy (Select one):

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

Please see XPOVIO™ (selinexor) Full Prescribing Information at XPOVIO.com

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5. Prescription Information

Patient's Name: ______________________ Date: ____ / ____ / ____

Rx for XPOVIO™ (selinexor) Quantity: ______ Refills: ______ **Start Date:** ____ / ____ / ____

Directions for Use: Take ______ 20 mg tablets (total ________ mg per dose) on days ________ and ________ of each week.

Additional Directions: ______________________

Prescriber's Name: ______________ Prescriber's Signature ______________ Date: ____ / ____ / ____

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

❑ *Please check here for patients who may need Quickstart*

6. Clinical Information

Patient's Diagnosis: ______________________ ICD-10 Code ______ Diagnosis Date: ______

Most Recent Therapies for this Diagnosis:

❑ Bortezomib ❑ Carfilzomib ❑ Daratumumab ❑ Ixazomib

❑ Lenalidomide ❑ Pomalidomide ❑ Other ____________

Prior Therapies for this Diagnosis:

❑ Bortezomib ❑ Carfilzomib ❑ Daratumumab ❑ Ixazomib

❑ Lenalidomide ❑ Pomalidomide ❑ Other ____________

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 that 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; (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.

Healthcare Professional's Name ______________________

Healthcare Professional's 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 to 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 that this authorization does not affect treatment from my healthcare professional or coverage for XPOVIO™ (selinexor) through my insurance. (8) I understand this authorization is voluntary. (9) However, if I refuse to sign, or cancel my authorization, KaryForward™ may not be able to determine my eligibility for the XPOVIO™ Co-Pay Card Program and XPOVIO™ (selinexor) Patient Assistant Program (PAP). (10) If I do not withdraw the 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's Signature ______________________ **Date:** ____ / ____ / ____

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

Please see XPOVIO™ (selinexor) Full Prescribing Information at XPOVIO.com

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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

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 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 dispense.

Section 5: XPOVIO™ (selinexor) QuickStart Prescription: Patients receiving their first XPOVIO™ (selinexor) prescription who cannot ascertain 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.

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