Dose Exchange Form

KaryForward's Dose Exchange Program can help you make necessary adjustments to your patient's XPOVIO® (selinexor) dose mid-cycle. ***For additional refills, a new prescription will need to be submitted to the patient's Specialty Pharmacy or an In Office Dispensing site.***

Complete. Carefully review and fill out this entire form.

Sign. Healthcare Professional must sign and date section 6. Patient must sign/date section 7.

Submit. FAX the completed form to **1-833-589-1603**

1 PATIENT INFORMATION

Patient Name (first last): _____

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

Mailing Address: _____

City: _____ State: _____ Zip: _____

Shipping Address: _____ (if different than mailing)

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Preferred Contact: ◯ Home Phone ◯ Cell Phone ◯ Email

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

Caregiver Name: _____

Caregiver Phone: _____

2 HEALTHCARE PROFESSIONAL/FACILITY INFORMATION

Prescriber Name (first last): _____

Prescriber Title: _____

NPI #: _____

DEA #: _____

Tax ID #: _____

Facility Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Office Contact Name: _____

Office Phone: _____ Fax: _____

3 DOSE EXCHANGE PRESCRIPTION *(select one from each section)*

CURRENT DOSE:

◯ 100 mg weekly ◯ 60 mg weekly

◯ 80 mg weekly ◯ Other: _____

NEW DOSE:

◯ 80 mg weekly ◯ 40 mg weekly

◯ 60 mg weekly ◯ Other: _____

TIME REMAINING IN CURRENT RX SUPPLY:

◯ 1 week ◯ 2 week ◯ 3 week

4 CLINICAL INFORMATION

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

5 CURRENT SPECIALTY PHARMACY *(select one)*

◯ In-office Dispensing Site Name/Phone: _____ ◯ Onco 360 ◯ Biologics, Inc.

6 HEALTHCARE PROFESSIONAL CERTIFICATION

By signing below, I certify that: 1) in my medical judgement, the new strength of XPOVIO® (selinexor) is clinically appropriate for the patient named on this form and the product prescription; 2) the XPOVIO tablets supplied under the Dose Exchange Program are specifically for the named patient; 3) the patient meets the eligibility criteria; and 4) I will not submit a claim for payment for the exchanged tablets and will inform the patient not to submit a claim.

◯ I attest that I have read the program terms and conditions to the patient and received confirmation from the patient that he/she understood and will comply with these terms and conditions.

Terms and conditions and eligibility criteria for the Dose Exchange Program can be reviewed on the following page or at karyforward.com.

HCP Name (print): _____

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

1-877-KARY4WD (1-877-527-9493)
Monday-Friday, 8 am to 8 pm ET

Karyopharm® Therapeutics

Please see full Prescribing Information for XPOVIO® (selinexor)

Dose Exchange Form

7 PATIENT CONSENT

I hereby authorize my healthcare professionals and my pharmacy to: (1) Disclose my protected health information (PHI) including, but not limited to, my name, address, telephone number, and medical records to KaryForward and its agents: (a) To contact me, or the person legally authorized to sign on my behalf, by phone or mail, and (b) to determine my eligibility for enrollment in the Dose Exchange Program.

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 understand that if I refuse to sign this authorization, it will not affect my treatment by my health-care professionals. 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: _____ /_____ /_____

8 ELIGIBILITY CRITERIA

- 18 years of age or older.
- U.S. or U.S. Territory residency.
- Patient has a valid prescription for XPOVIO®.
- Must have remaining tablets from a current prescription.
- Prescribing HCP must have decided to reduce the patient's dose of XPOVIO.

9 TERMS & CONDITIONS

- XPOVIO® Dose Exchange Program is available for up to two (2) separate dose exchanges per patient. The quantity of tablets to be exchanged in each dose exchange will not exceed a 28-day supply.
- Following receipt of the new dose, the patient must return all unused product to KaryForward by mail in the prepaid envelope provided in the shipment with the new dose.
- Neither the prescriber, prescriber's institution, pharmacy, pharmacist, or any other person, including the patient, may seek payment or accept reimbursement from any patient, any third-party payer, including any state or federal entity or any private or other insurance plan, or from any other person or entity, for XPOVIO supplied under this program, regardless of whether the payer subsequently determines it will cover the product.
- For XPOVIO tablets provided to Medicare Part D patients pursuant to the program, KaryForward shall notify such patients' Part D plans that product is being provided to these patients outside the Part D benefit, that no part of the costs of the drug provided as part of the program shall be counted towards any Part D patient's out-of-pocket costs, and that no claim will be filed with a Part D plan or by a Part D patient for such drug.
- If a patient is enrolled in a Medicare Part D plan, the patient must not attempt to count the free tablets provided under the program towards the patient's true out-of-pocket ("TrOOP") cost for prescription drug calculations.
- XPOVIO provided under this program may not be sold, traded, or distributed for sale.
- This program will provide a free supply of XPOVIO only. It does not cover any HCP services or any other costs associated with a dose reduction.
- The KaryForward program pharmacy will send the new dose strength and prepaid envelope direct to the patient.
- KPTI reserves the right to rescind, revoke, amend, or terminate this program at any time.

KaryForward.com

Please see full Prescribing Information for XPOVIO® (selinexor)