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. See notes on page 3 for more details.

Submit **both pages** of completed form via **FAX** to **1-833-589-1603**

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

Insurance Coverage
- ○ Benefit Investigation, Prior Authorization, Appeal Assistance
- ○ QuickStart Program
- ○ Bridge Program

Financial Assistance
- ○ Copay Program
- ○ Patient Assistance Program

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): _____
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: _____

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

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

Medicare ID: _____

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

Primary Insurance
Provider: _____
Provider Phone: _____
Cardholder Name: _____
Member ID/Policy #: _____
Group #: _____
PCN #: _____

Secondary Insurance
Provider: _____
Provider Phone: _____
Cardholder Name: _____
Member ID/Policy #: _____
Group #: _____
PCN #: _____

Prescription Insurance
Provider: _____
Provider Phone: _____
Cardholder Name: _____
Member ID/Policy #: _____
Group #: _____
PCN #: _____

Other Insurance
Provider: _____
Provider Phone: _____
Cardholder Name: _____
Member ID/Policy #: _____
Group #: _____
PCN #: _____

5 Preferred Specialty Pharmacy *(select one)*

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

KaryForward.com
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)

KaryFORWARD®
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6 Prescription Information

Patient Name: _____

QuickStart for first prescription? *(optional)* ◯ Yes

Prescriber Name (print): _____

SIGN HERE Prescriber: _____

Date: _____ /_____ /_____

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

Rx for XPOVIO® (selinexor) **START DATE:** ____ /____ /_____

Quantity of 20mg Oral Tablets: _____ Refills:_____

(select only one dosage):

- ◯ 100 mg once weekly
- ◯ 80 mg once weekly
- ◯ 60 mg once weekly
- ◯ 40 mg once weekly
- ◯ 80 mg twice weekly
- ◯ 60 mg twice weekly
- ◯ 40 mg twice weekly
- ◯ Other:_____

7 Clinical Information

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

8 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 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 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: _____ /_____ /_____

9 Patient Consent *(consent may also be provided electronically or verbally (see Section 9 notes on page 3 for details)**

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® Copay Program and for enrollment in the the Patient Assistance 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) Once my health information has been disclosed to KaryForward, I understand that federal privacy laws may no longer protect the information. (5) 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. (6) I understand this authorization does not affect treatment from my healthcare professional or coverage for XPOVIO® (selinexor) through my insurance. (7) I understand this authorization is voluntary. (8) However, if I refuse to sign, or cancel my authorization, KaryForward may not be able to determine my eligibility for the XPOVIO® Copay Program and the Patient Assistance Program (PAP). (9) 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 or Legal Representative Name (print):_____

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

◯ Yes, I understand the information provided by me, my healthcare professional, or insurance company may be used for marketing purposes about XPOVIO®, Karyopharm Therapeutics, or its patient support programs.

◯ I prefer to have a representative contact me to provide my consent verbally over the phone.

KaryForward.com

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)

KaryFORWARD®
PATIENT SUPPORT BY KARYOPHARM

Enrollment Form Notes

All form fields are required. Incomplete fields may cause processing delays.

Section 1 — **KaryForward Options**

Select any or all of the KaryForward support programs and services that meet the needs of your patient. Additional information about these programs can be found at karyforward.com.

Section 2 — **Healthcare Professional / Facility Information**

Including NPI and DEA numbers helps facilitate the benefits verification process.

Section 3 — **Patient Information**

If shipping address is different than mailing address, please be sure to indicate that here.

Section 4 — **Insurance Information**

If possible, please include a copy of both sides of the patient's insurance cards.

Section 5 — **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 6 — **Prescription Information**

This section can serve as the prescription for XPOVIO® for patients. Only one dosage may be selected.
Be sure to attach a separate prescription if this section does not comply with your state's prescription law.

Participation in the QuickStart Prescription program is optional and subject to eligibility requirements.

XPOVIO® (selinexor) will be delivered to the patient's mailing address unless a different shipping address has been provided in section 3.

A healthcare professional must sign and date the prescription.

Section 7 — **Clinical Information**

Clinical information is necessary as it is often requested when verifying benefits.

Section 8 — **Healthcare Professional Certification**

A healthcare professional must sign (no stamps) and date the enrollment form. The signature is required to attest to the review of the certification and consent.

Section 9 — **Patient Consent**

The patient (or a legal representative) must sign and date to provide consent. Alternate ways to provide consent:

- **electronically** by visiting https://karyforward.caremedsp.com/PatientConsent
- **verbally** by checking the box at the bottom of this section. A KaryForward representative will call the contact number provided in Section 3. The person giving the verbal consent must state their full name, relationship to patient along with the date and time before granting the verbal consent.

SUBMIT — **Completed Enrollment Form**

Submit **both pages** of the completed form via **FAX** to **1-833-589-1603**

If you're ready to enroll but have questions or need assistance, contact us at:

1-877-KARY4WD (1-877-527-9493)

Monday through Friday, 8AM to 8PM ET

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