**Please e-mail a signed electronic version of the completed form to:** KEAP@karyopharm.com

Importation of unapproved medications for Expanded Access treatment (AKA named patient or single patient INDs) by Special Licences Holders requires the following information:

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| **Name of Treating Physician** |  |
| **Name of Treating Hospital/Institution** |  |
| **Briefly describe the patient’s disease** |  |
| In your medical opinion, are there any commercially licensed treatments from which the patient would derive benefit? [ ]  Yes [ ]  No If Yes, Explain: |
| Are there any ongoing clinical trials which the patient qualifies for, can reasonably access, and could derive benefit?[ ]  Yes [ ]  No If yes, Explain:  |
| Signature of Treating Physician | Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| ***KARYOPHARM USE ONLY (to be completed by the assigned KEAP team leader)*** |
| Karyopharm agrees to support this application for Expanded Access Program consideration.Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| ***KARYOPHARM USE ONLY (to be completed by the assigned KEAP team representative)*** |
| Note: Forward page 1 of this KEAP request document along with the drug order form to the Special Import License Holder and/or drug distribution vendors. File the full KEAP request document in the appropriate tracking and documentation files. |
| Assigned KEAP Patient / Subject Number |  |

|  |  |
| --- | --- |
| **Patient’s Initials:**  | **Treating Physician:**  |
| **Please provide a summary of the patient’s disease, past treatments, and current medical status.** |
| Signature of Treating Physician | Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| ***KARYOPHARM USE ONLY (to be completed by the Medical representative)*** |
| Are there any ongoing selinexor clinical trials which the patient qualifies for, can reasonably access, and could derive benefit?[ ]  Yes [ ]  No If yes, Explain: |
| Have you reviewed the patient’s treatment history (page 2) and could the patient derive benefit from Expanded Access Treatment to selinexor alone or in combination? Recommended treatment dosing:I approve this patient medically for Karyopharm Expanded Access Program consideration [ ]  Yes [ ]  No |
| Signature of Medical Representative  | Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |