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

Importation of unapproved medications for Expanded Access treatment (also known as Named Patient or Single Patient INDs) by Special Licences Holders requires the following information:

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| **Name and position of the Treating Physician** |  |
| **Name of Treating Hospital/Institution** |  |
| **Briefly describe the patient’s disease** |  |
| For regulatory filing purposes, will the treating physician or the treating hospital/institution will be named on cross‑reference letters to selinexor INDs or IMPDs (if applicable). £ Physician £ Hospital/Institution |
| 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 and could derive benefit?£ Yes £ No If yes, Explain: If yes, can they reasonably access the clinical trial through an open clinical trial site? £ Yes £ No Please Explain: |
| Signature of Treating Physician | 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 |  |

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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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| **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 a KEAP medical representative)*****Please review the patient’s current status and treatment history and determine if the patient could derive benefit from Expanded Access Treatment to selinexor alone or in combination?** |
| Is there an ongoing selinexor clinical trials for which the patient qualifies and could benefit? Please be specific.£ Yes £ No Explain:If yes, can they reasonably access the clinical trial through an open clinical trial site? £ Yes £ No Explain:I approve this patient medically for Karyopharm Expanded Access Program consideration £ Yes £ NoRecommended treatment dosing: |
| Signature of Medical Representative  | Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |