ForYOU™ Patient Support Program

Pr XPOVIO® selinexor tablets

Prescription and Enrolment Form

Patient Information

First name: _____

Last name: _____

Date of birth: (YYYY / MM / DD) _____

Gender: ☐ Male ☐ Female ☐ _____

Health card number: _____

Allergies: ☐ NKA ☐ Please specify: _____

_____

Address: _____

City: _____ Province: _____

Postal code: _____

Preferred language: ☐ English ☐ French

Phone number: Primary: _____

Alternative: _____

Best time to contact me on weekdays:
☐ Morning ☐ Afternoon ☐ Evening

Consent to leave voicemail: ☐ Yes ☐ No

Email (optional)*: _____

* By providing your email, you consent to receiving electronic communications containing information and updates relating to the ForYOU™ Patient Support Program, your health condition(s), or your treatment(s). You can opt out of electronic communications at any time.

Patient caregiver or legal representative details (if applicable)

Name: _____

Relationship to patient: _____

Phone number: _____

Email: _____

Is the patient currently covered by a private insurance plan?
☐ Yes ☐ Unsure ☐ No

If yes, has an application for insurance coverage for XPOVIO been made?
☐ Yes ☐ No

Physician Information

Physician first name: _____

Physician last name: _____

Cancer centre name: _____

Cancer centre address: _____

City: _____

Province: _____ Postal code: _____

Phone number: _____

Fax number: _____

Email: _____

Preferred method of contact: ☐ Phone ☐ Fax ☐ Email

Additional Healthcare Team Information
(i.e., DAN, DAC, Pharmacist)

Name: _____ Role: _____

Phone number: _____ Fax number: _____

Email: _____

Preferred method of contact: ☐ Phone ☐ Fax ☐ Email

Treatment Information

Indication

☐ XPOVIO® (selinexor) in combination with bortezomib and dexamethasone for the treatment of adult patients with multiple myeloma who have received at least one prior therapy.

Line of therapy: ☐ 2L ☐ 3L ☐ 4L+

Anticipated treatment start date: _____
(YYYY / MM / DD)

Prescription and Physician Consent

XPOVIO® (selinexor)

Dosage:†

☐ 100 mg once weekly for 5 weeks (1 cycle)
☐ 80 mg once weekly for 5 weeks (1 cycle)
☐ 60 mg once weekly for 5 weeks (1 cycle)
☐ 40 mg once weekly for 5 weeks (1 cycle)
☐ Other: _____
_____

SIGN HERE

SIGNATURE OF PHYSICIAN Date (YYYY / MM / DD)

By signing, you indicate you have read, understand, and agree to the physician consent and privacy statement on the reverse.

Physician licence number: _____

† The recommended starting dose of XPOVIO® is 100 mg once weekly. Please see the XPOVIO® Product Monograph at xpoviopm.ca for more information.

Please send both pages 1 and 2 of the completed form:
by email: xpovio@foryoupsp.com
by fax: 1-833-4YOUFAX (1-833-496-8329)

For more information, please call 1-833-4YOUPSP (1-833-496-8777).

NKA, no known allergies.

ForYOU™ Patient Support Program

Pr XPOVIO® selinexor tablets

Patient Consent and Privacy Statement

The purpose of the ForYOU™ Patient Support Program ("**Program**") is to provide patients with support, including reimbursement navigation and other services, related to XPOVIO® (selinexor) treatment regimens (the "**Product**").

The Program is managed by FORUS Therapeutics Inc. ("**FORUS**") and administered by Innomar Strategies Inc. ("**Program Administrator**"). FORUS may appoint a new program administrator at any time. By signing this form, you consent to the transfer of your personal information, as well as the prescription itself (if applicable), to any future program administrator, if required.

You understand that the Program is not intended to provide medical advice or medical diagnoses. You should always seek the advice of your physician if you have any health concerns. You have discussed the benefits and risks of the Product with your physician and have decided to start treatment. You understand that signing this consent form is voluntary. However, if you do not sign this consent form you will not have access to the supports provided through the Program.

FORUS reserves the right at any time, without notice, to modify, discontinue or terminate the Program.

By signing this form, you agree to enrol in the Program and authorize for your information, including contact information and information about your insurance, prescriptions, medical condition, diagnostic test results and other health information from your health care providers ("**Personal Information**") to be collected, used and disclosed as described below. You also consent to the Program Administrator contacting you or any caregiver or legal representative you identify to provide the Program services and evaluate its effectiveness and agree that the Program Administrator may share your Personal Information with your caregiver or legal representative for these purposes. Telephone calls with the Program Administrator may be monitored or recorded for quality control and training purposes.

Personal Information: Collection, Use and Disclosure

The Personal Information provided on this form will be shared with the Program Administrator for the purposes of administering and providing services under the Program. For these purposes, the Program Administrator may also collect Personal Information from your insurer(s) and healthcare providers. Personal information may also be collected from healthcare providers in the context of an adverse drug event.

Your Personal Information may be disclosed to:

- FORUS for Program auditing and troubleshooting purposes, to fulfill its adverse drug event reporting and complaints handling obligations to Health Canada, and in the event of a special request requiring pre-authorization from FORUS;
- Public and private insurers for the purpose of investigating drug reimbursement options; and
- Healthcare provider(s) in connection with an adverse drug event or for the purpose of investigating drug reimbursement options. Healthcare provider(s) may further share your Personal Information with Health Canada or insurer(s) for these purposes.

Personal Information may also be disclosed in other circumstances where required by applicable law, including applicable foreign laws.

Personal Information may also be shared with service providers who perform certain services on behalf of the Program Administrator or FORUS in connection with the Program.

The Program Administrator may share de-identified Personal Information with FORUS. When Personal Information is de-identified, direct identifiers will be replaced with a unique code or removed altogether. FORUS may use de-identified data for purposes such as real-world evidence data collection, market research, clinical publications, and internal evaluation. FORUS may also use the de-identified data to generate aggregate information. Aggregate data may be shared with third parties. These third parties are required to agree not to attempt to re-identify anyone from the aggregate data.

Your Personal Information will be protected by reasonable physical, administrative, and technical safeguards to protect it against loss, theft and unauthorized consultation, communication, copying, use or alteration.

Personal Information may be transferred, stored, or processed outside of Canada, including in the United States. While outside of Canada, Personal Information will be subject to applicable foreign laws, which may not offer the same protections for Personal Information as the laws in Canada.

You may withdraw your consent at any time by contacting the Program Administrator at 1-833-4YOUPSP (1-833-496-8777). If you withdraw your consent, you will no longer have access to the services provided under the Program. Your withdrawal of consent will not be retroactive and any activities relating to your Personal Information prior to your withdrawal will not be affected. If you have questions about the handling of your Personal Information in connection with the Program, or if you would like to request access to or correction of your Personal Information collected in connection with the Program, you may contact the Program Administrator at the telephone number above and ask to speak with the Privacy Officer.

Patient name: _____

☐ I have read, understand, and agree to the patient consent and privacy statement.

_____

Signature of patient or legal representative — Date (YYYY / MM / DD)

If I am signing as the patient's legal representative, I represent and warrant that I am the legal representative of the patient, and that I have authority to provide this consent on the patient's behalf.

OR

☐ Patient has given verbal consent to proceed with enrolment at this time.

Verbal consent obtained by: _____

_____

Signature of person obtaining verbal consent — Date (YYYY / MM / DD)

Physician Consent and Privacy Statement

You confirm that the patient identified on this form is under your care and qualifies for the Product, and that you have explained the Program to the patient. You confirm that the prescription represents the original Product prescription for the patient, and that any other prescription for the Product has been cancelled and securely filed and will not be transmitted elsewhere at another time. You authorize the Program Administrator to forward the prescription by fax or other mode of delivery to the Program specialty pharmacy or to another pharmacy chosen by the patient. You consent to be contacted by the Program Administrator about the patient, the Product, adverse events and complaints relating to the Product. You agree that your contact information and prescribing information may be shared with FORUS for the purposes of auditing and improving the Program as well as in connection with adverse events, information and education needs, research purposes, and as otherwise permitted by law. You understand that you may be contacted by a FORUS Medical Science Liaison to ensure that your medical information needs are met. Information collected in connection with the Program may be processed and stored inside or outside of Canada. You agree to keep all information about the Program confidential and not to disclose it to any third party except as authorized by FORUS.

Submit

MED-CA-XP-2200133

FORUS THERAPEUTICS