Patient Start Form Guide

Getting started is simple. Just fill out and submit the Patient Start Form when initiating a patient on LUPKYNIS™ (voclosporin). The Start Form acts as a prescription and enrolls patients in the Aurinia Alliance™ program.

Before submitting the Start Form, it is important to:

1. Double-check the form to ensure all fields are completed
2. Confirm all signature fields are filled in by both you and your patient. Patient signature enrolls your patient in Aurinia Alliance, a program that provides patient support, including funding support for your eligible patients[a]
3. Ensure you have the correct documentation that may need to be sent with the Start Form
   - Copies of insurance cards may be needed

The Start Form may be submitted via one of the following methods:

Fax:
1-833-213-1001
(preferred method)

Mail:
Aurinia Alliance
PO Box 5490
Louisville, KY 40255

Questions? Call **1-833-AURINIA (1-833-287-4642)** 8AM-8PM ET, or email Aurinia Alliance at **support@AuriniaAlliance.com** for additional assistance

LUPKYNIS may also be prescribed electronically (eRx)

Simply send the eRx to Aurinia Alliance. PharmaCord® (NABP 1836191) is the pharmacy that will transfer the eRx to one of the Aurinia Alliance contracted pharmacies to fill your patient's prescription. Depending on your eRx system, you may need to enter the brand name (LUPKYNIS), the generic (voclosporin), or the LUPKYNIS NDC number:

- NDC 75626-001-01: Wallet containing 60 capsules
- NDC 75626-001-02: Carton containing 180 capsules (3 wallets)

[a]Patient signature required to access Aurinia Alliance support, not to prescribe LUPKYNIS.

Please see Prescribing Information including Boxed Warning and Medication Guide for LUPKYNIS.

Submission Instructions for the Simple, Single-page Start Form

The patient completes the following:

Patient details

Be sure the patient fills out the information completely, including the preferred method of contact.

- The patient should indicate if leaving voice messages and/or text messages is appropriate
- The patient should fill out their language preference for communication

Insurance information

The patient must completely fill out all insurance information as it applies. Please make sure to include copies of insurance cards when submitting the Start Form.

Patient signature

If the patient agrees to the Authorization to Share Health Information and participation in Aurinia Alliance terms (see page 2 of the Start Form), ensure their or their legal guardian's signature is included, along with the date.

Questions? Phone: 1-833-AURINIA (1-833-287-4642) | Email: support@AuriniaAlliance.com

Aurinia Alliance

Patient Start Form

Fax: 1-833-213-1001 (please fax the completed Start Form)

Lupkynis (voclosporin) capsules 7.9 mg

Patient Information

First Name: Jane Last Name: Smith
Date of Birth (mm/dd/yyyy): 09/08/1984 Gender: ☐ Male ☑ Female
Last 4 Digits of SSN (for insurance verification purposes): 7890
Address: 456 Everytown Street
City: Everytown State: MD ZIP Code: 20717
Phone (check preferred): ☑ Mobile: 555 - 123 - 4567 ☐ Home: ___-___-___
OK to Leave Messages? ☑ Yes ☐ No
OK to Send Text Messages? ☑ Yes ☐ No
Email: jsmith@email.com
Primary language: ☑ English ☐ Spanish ☐ Other

Insurance Information

☑ Insured (complete this section) ☐ Uninsured (skip this section)
Please provide front/back copies of insurance card
Primary Insurer/PBM Name: ABC Insurance
Plan Name: ABC Plan
Insurer/PBM Phone: 555 - 123 - 7788
Policyholder Name: Jane Smith
Policyholder Relationship to Patient: Self
Policyholder DOB (mm/dd/yyyy; only if different from patient):
Policy ID #: 1234567
Group #: ABC123
Rx BIN: Rx PCN #: Rx Group #:
Issuer: ID #:
☐ If the patient has secondary insurance, please check this box and attach copy of insurance card

Patient Certification and Authorization

By signing below, I confirm that I have read and understand the Authorization to Share Health Information and Patient Support on page 2 and agree to the terms.
☑ I would like to opt in for other programs and resources from Aurinia and agree to the terms and conditions on page 2 (optional)
Printed Patient Name: Jane Smith
Patient or Authorized Representative Signature: [signature] **Signature Date (mm/dd/yyyy):** 08/31/2021

Clinical and Prescriber Information

Prescriber First Name: Michael Prescriber Last Name: Sample
Specialty: ☐ Nephrology ☑ Rheumatology ☐ Immunology ☐ Other (please specify):
NPI #: 1234567890 Site/Facility/Practice Name: Sample Practice
Office Address: 123 Sample Street
City: Any Town State: MD ZIP Code: 00122 Office Contact Name: Sarah Reed
Phone: 555 - 445 - 7788 Ext. (if applicable): Fax: 555 - 445 - 5677 Email: Sample@email.com

Prescription

Diagnosis Code: ☑ M32.14 Lupus Nephritis ☐ Other
Kidney Biopsy Date (if available): 01/08/2021 Class: III
eGFR: ____ mL/min/1.73 m²

LUPKYNIS™ (voclosporin)
Recommended starting dose is 3 capsules BID. Please see Prescribing Information for guidance on potential dosing adjustments.

☐ 23.7 mg (7.9 mg/capsule) PO BID x 30 days # 180 capsules ____ refills
☐ 15.8 mg (7.9 mg/capsule) PO BID x 30 days # 120 capsules ____ refills
☐ 7.9 mg (7.9 mg/capsule) PO BID x 30 days # 60 capsules ____ refills

Drug Allergies: ☐ Yes ☐ No
If Yes, Please List:
Concurrent Medications (please list):
Has the Patient Previously Taken LUPKYNIS? ☐ Yes ☐ No ☐ Unknown

LUPKYNIS Bridge Prescription Information: Prescriber to complete only if Bridge is requested

Complete this additional (optional) prescription for LUPKYNIS, which can provide a limited supply of LUPKYNIS at no cost to eligible patients who experience a delay in insurance coverage. The shipment will be made to the patient address designated on this page. For eligibility criteria, contact Aurinia Alliance at 1-833-287-4642.

☐ 23.7 mg (7.9 mg/capsule) PO BID x 30 days # 180 capsules 1 refills
☐ 15.8 mg (7.9 mg/capsule) PO BID x 30 days # 120 capsules 1 refills
☐ 7.9 mg (7.9 mg/capsule) PO BID x 30 days # 60 capsules 1 refills

Patient Certification and Authorization (above) must be complete for participation in Bridge program.

Prescriber Certification and Authorization

By signing below, I certify that (1) LUPKYNIS as I prescribed is medically necessary and is in the best interest of the patient listed above; (2) I have reviewed the current Product prescribing information before prescribing; (3) I have obtained written consent required under federal and state law for the release of the patient's personal health information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations thereunder) on this form to Aurinia Pharma US ("Aurinia") and its Contractors and business partners ("Contractors") for benefits verification and coordination of dispensing Aurinia medicine; (4) I will comply with state-specific prescription requirements and understand non-compliance with these requirements could result in further outreach by the patient's specialty pharmacy; (5) I understand that information I provide on this form, if signed by the patient, will be used by Aurinia and its Contractors as authorized by the patient. I authorize Aurinia to forward the above prescription to the applicable pharmacy.
For Bridge program: I understand that this medication is being provided free to the named patient by Aurinia and agree that neither I nor the patient will bill an insurer or any government healthcare program for the cost of this medication. The Bridge program may not be combined with another offer and is not eligible to patients without insurance or whose insurer has made a final coverage determination. Patients must be residents of the US for 6 months or more and have a US mailing address.

Prescriber Signature (dispense as written): [signature] **Signature Date (mm/dd/yyyy):** 08/31/2021

Please see accompanying Prescribing Information including Boxed Warning and Medication Guide for LUPKYNIS.

1 of 2

Please see Prescribing Information including Boxed Warning and Medication Guide for LUPKYNIS.

Submission Instructions for the Simple, Single-page Start Form (cont.)

The HCP or office staff completes the following:

Specialty and NPI number

Please specify your medical specialty. Be sure to include your 10-digit NPI number.

Prescription

Please be sure to fill out the diagnosis code/ICD-10 code associated with the patient. The last kidney biopsy date should also be included, along with the specific class of disease.

- The most common prescription dose is highlighted in purple

Bridge prescription information

The optional Bridge program is available to help patients access LUPKYNIS while they are awaiting insurance coverage determination. Patients may receive a limited supply of LUPKYNIS at no cost. Call Aurinia Alliance for eligibility criteria.

- The most common prescription dose is highlighted in purple

Prescriber signature

Ensure your signature and the date are included.

Questions? Phone: 1-833-AURINIA (1-833-287-4642) | Email: support@AuriniaAlliance.com

Aurinia Alliance

Patient Start Form

Fax: 1-833-213-1001 (please fax the completed Start Form)

Lupkynis (voclosporin) capsules 7.9 mg

Patient Information

First Name: Jane Last Name: Smith
Date of Birth (mm/dd/yyyy): 09/08/1984 Gender: ☐ Male ☑ Female
Last 4 Digits of SSN (for insurance verification purposes): 7890
Address: 456 Everytown Street
City: Everytown State: MD ZIP Code: 20717
Phone (check preferred): ☑ Mobile: 555 - 123 - 4567 ☐ Home: ___ - ___ - ___
OK to Leave Messages? ☑ Yes ☐ No
OK to Send Text Messages? ☑ Yes ☐ No
Email: jsmith@email.com
Primary language: ☑ English ☐ Spanish ☐ Other

Insurance Information

☑ Insured (complete this section) ☐ Uninsured (skip this section)
Please provide front/back copies of insurance card
Primary Insurer/PBM Name: ABC Insurance
Plan Name: ABC Plan
Insurer/PBM Phone: 555 - 123 - 7788
Policyholder Name: Jane Smith
Policyholder Relationship to Patient: Self
Policyholder DOB (mm/dd/yyyy; only if different from patient): ______
Policy ID #: 1234567
Group #: ABC123
Rx BIN: ______ Rx PCN #: ______ Rx Group #: ______
Issuer: ______ ID #: ______
☐ If the patient has secondary insurance, please check this box and attach copy of insurance card

Patient Certification and Authorization

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☑ I would like to opt in for other programs and resources from Aurinia and agree to the terms and conditions on page 2 (optional)

Printed Patient Name: Jane Smith
Patient or Authorized Representative Signature: [signature] **Signature Date (mm/dd/yyyy):** 08/31/2021

Clinical and Prescriber Information

Prescriber First Name: Michael Prescriber Last Name: Sample
Specialty: ☐ Nephrology ☑ Rheumatology ☐ Immunology ☐ Other (please specify): ______
NPI #: 1234567890 Site/Facility/Practice Name: Sample Practice
Office Address: 123 Sample Street
City: Any Town State: MD ZIP Code: 00122 Office Contact Name: Sarah Leed
Phone: 555 - 445 - 7788 Ext. (if applicable): ______ Fax: 555 - 445 - 5677 Email: Sample@email.com

Prescription

Diagnosis Code: ☑ M32.14 Lupus Nephritis ☐ Other ______
Kidney Biopsy Date (if available): 01/08/2021 Class: III
eGFR: ______ mL/min/1.73 m²

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☐ 15.8 mg (7.9 mg/capsule) PO BID x 30 days # 120 capsules ____ refills
☐ 7.9 mg (7.9 mg/capsule) PO BID x 30 days # 60 capsules ____ refills

Drug Allergies: ☐ Yes ☐ No
If Yes, Please List: ______
Concurrent Medications (please list): ______
Has the Patient Previously Taken LUPKYNIS? ☐ Yes ☐ No ☐ Unknown

LUPKYNIS Bridge Prescription Information: Prescriber to complete only if Bridge is requested

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☐ 23.7 mg (7.9 mg/capsule) PO BID x 30 days # 180 capsules 1 refills
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☐ 7.9 mg (7.9 mg/capsule) PO BID x 30 days # 60 capsules 1 refills

Patient Certification and Authorization (above) must be complete for participation in Bridge program.

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Prescriber Signature (dispense as written): [signature] **Signature Date (mm/dd/yyyy):** 08/31/2021

Please see accompanying Prescribing Information including Boxed Warning and Medication Guide for LUPKYNIS. 1 of 2

Please see Prescribing Information including Boxed Warning and Medication Guide for LUPKYNIS.

Questions? Call **1-833-AURINIA (1-833-287-4642)** 8AM-8PM ET, or email Aurinia Alliance at **support@AuriniaAlliance.com** for additional assistance

Please see Prescribing Information including Boxed Warning and Medication Guide for LUPKYNIS.

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