Start Form Guide

How to complete the Start Form so you can quickly begin treatment for your patients

Aurinia Alliance™

Lupkynis™ (voclosporin) capsules 7.9 mg

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

Patient Start Form

Submission Instructions

Getting started is simple. Just fill out and submit the following Patient Start Form when initiating a patient on LUPKYNIS™ (voclosporin).

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.

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For Patients

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

Aurinia Alliance

Patient Start Form

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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

Do You Speak English? ☑ Yes ☐ No If No, What Is Your Spoken Language? ___

Insurance Information

☑ Insured (complete this section) ☐ Uninsured (skip this section)

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 #: ___

Secondary Insurer/PBM Name: ___ Plan Name: ___

Insurer/PBM Phone: ___ - ___ - ___

Policyholder Name: ___ Policyholder Relationship to Patient: ___

Policyholder DOB (mm/dd/yyyy; only if different from patient): ___

Policy ID #: ___ Group #: ___

Rx BIN: ___ Rx PCN #: ___ Rx Group #: ___ Issuer: ___ ID #: ___

PBM=Pharmacy Benefit Manager.

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Patient name

The patient's name is needed on each page to ensure appropriate processing.

Primary phone number and OK to leave messages

Your patient must check off their preferred method of phone contact and fill out the primary phone number. The patient should make sure to indicate if leaving voice messages and/or text messages is appropriate, as there may be important information to be relayed regarding the prescription.

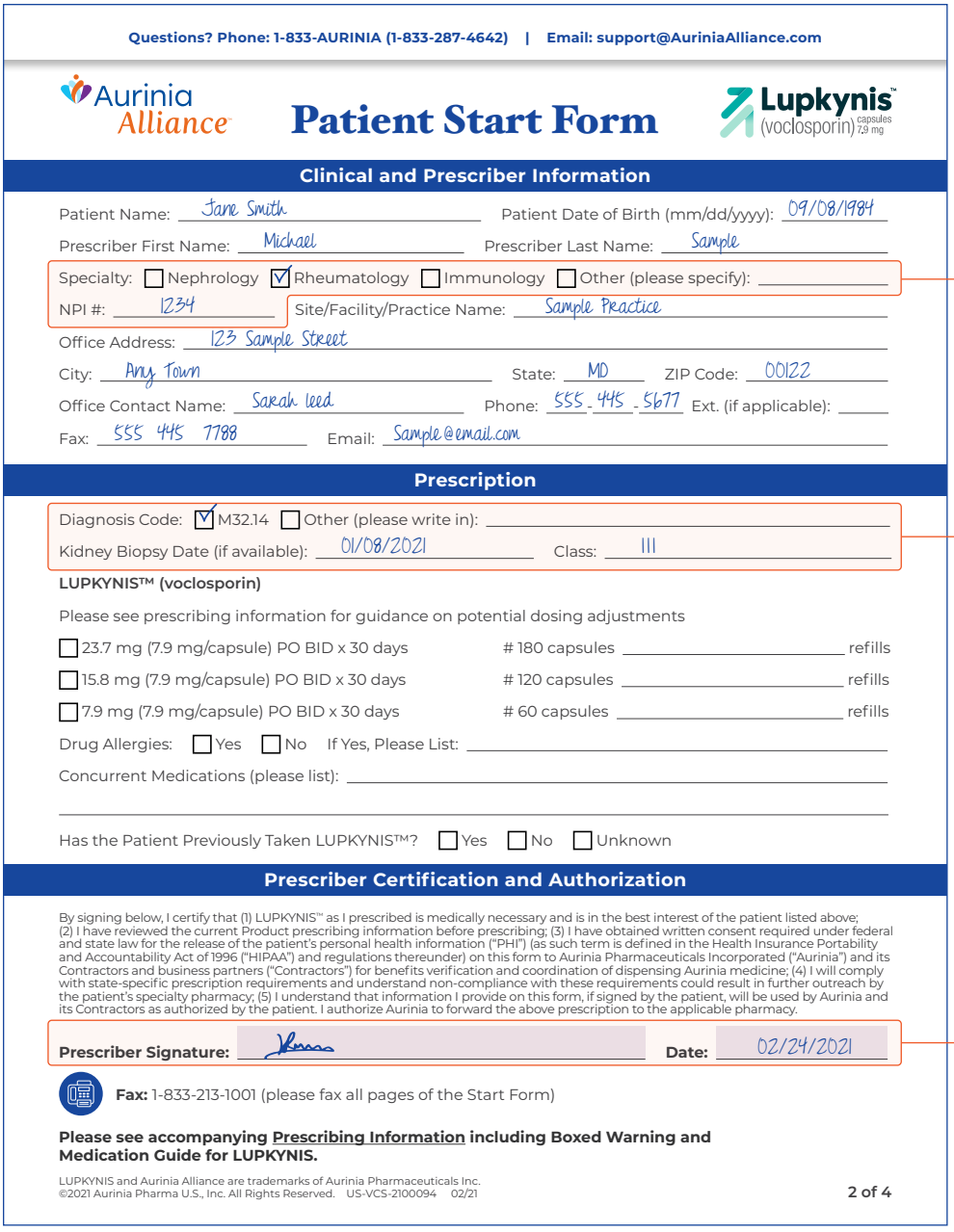
Language preference

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.

For Healthcare Providers



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Aurinia Alliance

Patient Start Form

Lupkynis™ (voclosporin) capsules 7.9 mg

Clinical and Prescriber Information

Patient Name: Jane Smith Patient Date of Birth (mm/dd/yyyy): 09/08/1984

Prescriber First Name: Michael Prescriber Last Name: Sample

Specialty: ☐ Nephrology ☑ Rheumatology ☐ Immunology ☐ Other (please specify): _____

NPI #: 1234 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: 555-445-5677 Ext. (if applicable): _____

Fax: 555 445 7788 Email: Sample@email.com

Prescription

Diagnosis Code: ☑ M32.14 ☐ Other (please write in): _____

Kidney Biopsy Date (if available): 01/08/2021 Class: III

LUPKYNIS™ (voclosporin)

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

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 Pharmaceuticals Incorporated ("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.

Prescriber Signature: _____ **Date:** 02/24/2021

Fax: 1-833-213-1001 (please fax all pages of the Start Form)

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

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Specialty and NPI number

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

Prescription

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.

Prescriber signature

Ensure your signature and date are included.

Privacy Authorization

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Patient Start Form

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Privacy Authorization

Patient Name: Jane Smith Patient Date of Birth (mm/dd/yyyy): 09/08/1984

Patient Phone Number: 555 - 123 - 4567 Patient Email: jsmith@email.com

Authorization to Share Health Information: By signing this Authorization, I authorize my healthcare provider, my health insurance company, and my p
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and r
limite
other
and c
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Patient Start Form

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Privacy Authorization (continued)

Patient Name: Jane Smith Patient Date of Birth (mm/dd/yyyy): 09/08/1984

Patient Support: I authorize Aurinia to contact me to provide me support related to any of Aurinia's products, including but not limited to financial assistance services, adherence and other therapy support services, relevant disease-related information, as well as any information or materials related to such services. I understand that any nurse providing support as part of an Aurinia program is not employed by my healthcare professional. Aurinia may contact me by mail, email, fax, telephone call, text message (including calls and text messages made with an automatic telephone dialing system or a prerecorded voice), and other mutually agreed upon means. I also authorize Aurinia to use my health information in connection with the services and programs, including, without limitation, sharing such information with my Healthcare Entities. I also authorize the disclosure of my health information to specific individuals that I have designated below.

☐ **Opt-in for Other Resources (optional)**

Aurinia would like to contact you regarding other programs and resources that may be of interest to you. By checking this box, I authorize Aurinia to contact me by mail, email, fax, and/or telephone regarding other potential topics of interest to me, customer surveys, or occasionally for market research purposes. I understand that I am not required to provide this consent as a condition of receiving any Aurinia medicine or Patient Support Services.

I have read and understand the Authorization to Share Health Information and Patient Support, and agree to the terms.

Printed Patient Name: Jane Smith

Patient or Authorized Representative Signature: Jane Smith

Signature Date (mm/dd/yyyy): 02/24/2021

If Authorized Representative:

Print Name: _____ Relationship: _____

Please specify any additional contacts with whom Aurinia Alliance is allowed to discuss your information:

Additional Contact Name: John Smith Relationship to Patient: Husband

Additional Contact Name: Jessica Anderson Relationship to Patient: Mother

Fax: 1-833-213-1001 (please fax all pages of the Start Form)

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

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Patient signature

If the patient agrees to the Authorization to Share Health Information and the participation in Aurinia Alliance terms, ensure their or their legal guardian's signature is included, along with the date.

Additional contact

If the patient has any additional contacts that Aurinia Alliance can contact with their information, please fill in their name and relationship to the patient.

Aurinia Alliance™

Dedicated Support, Personalized For You

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US-VCS-2100096 02/21

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