Aurinia Alliance™

Patient Start Form

Lupkynis™ (voclosporin) capsules 7.9 mg

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.

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

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Patient Information

First Name: _____ Last Name: _____

Date of Birth (mm/dd/yyyy): _____ Gender: ☐ Male ☐ Female

Last 4 Digits of SSN (for insurance verification purposes): _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone (check preferred): ☐ Mobile: _____-_____-_____ ☐ Home: _____-_____-_____

OK to Leave Messages? ☐ Yes ☐ No OK to Send Text Messages? ☐ Yes ☐ No

Email: _____

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: _____ 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 #: _____

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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Clinical and Prescriber Information

Patient Name: _____ Patient Date of Birth (mm/dd/yyyy): _____

Prescriber First Name: _____ Prescriber Last Name: _____

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

NPI #: _____ Site/Facility/Practice Name: _____

Office Address: _____

City: _____ State: _____ ZIP Code: _____

Office Contact Name: _____ Phone: ____-____-____ Ext. (if applicable): _____

Fax: _____ Email: _____

Prescription

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

Kidney Biopsy Date (if available): _____ Class: _____

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:** _____

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Privacy Authorization

Patient Name: _____ Patient Date of Birth (mm/dd/yyyy): _____

Patient Phone Number: _____-_____-_____ Patient Email: _____

Authorization to Share Health Information: By signing this Authorization, I authorize my healthcare provider, my health insurance company, and my pharmacy providers ("Healthcare Entities") to disclose to Aurinia, and companies working with Aurinia (collectively, "Aurinia"), health information relating to my medical condition, treatment, and insurance coverage for Aurinia to provide me with (i) support services (and related information and materials) related to any of Aurinia's products, including but not limited to, online support, financial assistance services, adherence and other therapy support services, (ii) conduct data analytics, market research and other internal business activities, and (iii) information about Aurinia's products, services, and programs. Once my health information has been disclosed to Aurinia, I understand that federal privacy laws no longer protect the information. However, Aurinia agrees to protect my health information by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations. I understand that my pharmacy provider may receive remuneration from Aurinia in exchange for the health information and/or for any therapy support services provided to me. I understand that I may refuse to sign this Authorization. I further understand that my treatment (including with an Aurinia product), payment for treatment, insurance enrollment or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization; but if I do not sign it or later cancel it, I will not be able to receive Aurinia's patient program support. I may cancel this Authorization at any time by calling 1-833-AURINIA or mailing a letter to: Aurinia Alliance, PO Box 5490, Louisville, KY 40255. Canceling this Authorization will end my consent to further disclosure of my health information to Aurinia by my Healthcare Entities after they are notified of my cancellation but will not affect previous disclosures by them pursuant to this Authorization. Canceling this Authorization will not affect my ability to receive treatment, payment for treatment, or my eligibility for health insurance. This Authorization expires five (5) years from the date signed, unless a shorter period is required by state law.

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Privacy Authorization (continued)

Patient Name: _____ Patient Date of Birth (mm/dd/yyyy): _____

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: _____

Patient or Authorized Representative Signature: _____

Signature Date (mm/dd/yyyy): _____

If Authorized Representative:

Print Name: _____ Relationship: _____

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

Additional Contact Name: _____ Relationship to Patient: _____

Additional Contact Name: _____ Relationship to Patient: _____

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