To:	Aurinia Alliance	**Fax:**	833-213-1001
Re:	HCP Consent for Aurinia Alliance Services	**Phone:**	833-287-4642
Date:		**Email:**	support@auriniaalliance.com

HCP Consent for Aurinia Alliance Services

Prescriber Full Name: _____ NPI: _____

Prescriber Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Prescriber Certification and Authorization: By signing below, I certify that for all prescriptions for LUPKYNIS® that I submit to Aurinia Alliance™ through our e-prescribing system or via facsimile:

(1) LUPKYNIS® as I prescribed is medically necessary and is in the best interest of the patient listed on the Start Forms.

(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 including but not limited to my patient's healthcare care data and health care plan information) on this form to Aurinia Pharmaceuticals Incorporated ("Aurinia") and its contractors and business partners ("Contractors") for benefits verification, and coordination of dispensing Aurinia medicine and for enrollment in services offered by Aurinia Alliance.

(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 all submitted Start Forms to the transmit the prescription to the applicable dispensing pharmacy.

(6) 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.

This Certification and Authorization shall be valid for 5 years, or unless otherwise revoked by me via written notice to Aurinia Alliance.

For all medications that may be provided through the Aurinia Alliance Patient Programs - Bridge and PAP:

I certify I will not bill any third-party payer or any government healthcare program for the costs of the medication provided free of charge by Aurinia for my patients. The Aurinia bridge program is not eligible to patients without insurance or whose insurer has made a final coverage determination.

Prescriber Signature: _____ Date: _____