Fax completed form to PharmaCord: 1-833-213-1001

Aurinia Alliance®

Patient Start Form

Questions? Call: 1-833-AURINIA (1-833-287-4642) | Email: support@AuriniaAlliance.com
Secondary Fax: 1-502-509-0549

Lupkynis® (voclosporin) capsules 7.9 mg

Patient Information

First Name: _____ Last Name: _____

Date of Birth (mm/dd/yyyy): _____ Sex: ☐ 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: _____

Prefered language: ☐ English ☐ Spanish ☐ Other _____

Insurance Information

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

☐ **Attached front/back copies of medical, prescription, and secondary insurance cards (if available)**

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 #: _____

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: _____ **Authorized Representative Name:** _____

Authorized Representative Phone #: _____

Patient Signature: _____ **Signature Date (mm/dd/yyyy):** _____

Prescriber Information

Prescriber: First Name: _____ Last Name: _____ **NPI #:** _____

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

Site/Facility/Practice Name: _____

Office Address: _____

City: _____ State: _____ ZIP Code: _____ Office Contact Name: _____

Phone: ___-___-____ Ext. (if applicable): _____ Fax: ___-___-____ Email: _____

Prescription and Bridge Prescription

Diagnosis Code:

☐ **M32.14 Lupus Nephritis**

☐ **M32.10 systemic lupus erythematosus, organ or system involvement unspecified**

☐ Other _____

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

Bridge Prescription: Complete this (optional) prescription which can provide a limited supply of LUPKYNIS at no cost to eligible patients who experience a delay in insurance coverage. Patient Certification and Authorization (above) is required. For eligibility criteria, contact Aurinia Alliance at 1-833-287-4642.

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 2 refills

☐ 15.8 mg (7.9 mg/capsule) PO BID x 30 days # 120 capsules 2 refills

☐ 7.9 mg (7.9 mg/capsule) PO BID x 30 days # 60 capsules 2 refills

Items to include with Submission of Patient Start Form

To aid in the prior authorization process please provide the following clinical chart notes and lab results, if available:

☐ Confirmation of SLE diagnosis and date diagnosed

☐ Confirmation or lupus nephritis (LN) diagnosis, date diagnosed, ISN classification, and renal biopsy/pathology report

☐ Laboratory testing (ANA or other relevant auto-antibody testing [dsDNA], UPCR, C3, C4, and eGFR)

☐ Notes from consultation with a Nephrologist or Rheumatologist

☐ All current and previous therapies used to treat LN and the reason for treatment failure

☐ Reason this LN therapy is the preferred treatment

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. (6) For all medications that may be provided by the Aurinia Alliance Patient Programs (Bridge and PAP), I understand that this medication is being provided free of charge to the named patient by Aurinia and agree that I nor the patient will bill an insurer or any government healthcare program for the cost of this medication. Patients must be residents of the US for 6 months or more and have a US mailing address. The Bridge program is not eligible to patients without insurance or whose insurer has made a final coverage determination.

Prescriber Signature (dispense as written): _____ **Signature Date (mm/dd/yyyy):** _____

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

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Secondary Fax: 1-502-509-0549

Lupkynis® (voclosporin) capsules 7.9 mg

Privacy Authorization

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.

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: By checking the box on page 1, 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.

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