Aurinia Alliance

Patient Start Form

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

Lupkynis™ (voclosporin) capsules 7.9 mg

Submission Instructions

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.

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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: _____

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: _____
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 #: _____

☐ 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: _____

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

Clinical and Prescriber Information

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 Lupus Nephritis ☐ Other _____
Kidney Biopsy Date (if available): _____ Class: _____
eGFR: _____ mL/min/1.73 m²

Drug Allergies: ☐ Yes ☐ No
If Yes, Please List: _____

Concurrent Medications (please list): _____

Has the Patient Previously Taken LUPKYNIS?
☐ Yes ☐ No ☐ Unknown

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

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

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

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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.