Patient Enrollment Form

Welcome to Aurinia Alliance™. To enroll, follow the steps below:

1. Fill out your information on **Page 2**. Each field is required. If you need help, call 1-833-AURINIA to be connected with someone who can help you complete the enrollment form.

2. Fill out and sign **Page 3**.

3. Mail your completed form to **Aurinia Alliance PO Box 5490 Louisville, KY 40255**, or email it to **Support@AuriniaAlliance.com**.

4. Once we've received and processed your enrollment form, you'll be partnered with a Nurse Case Manager—they'll be your dedicated contact.

Dedicated support, personalized for you.

Questions? Call 1-833-AURINIA (1-833-287-4642) 8AM-8PM EST or email Aurinia Alliance at Support@AuriniaAlliance.com for additional assistance

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Aurinia Alliance

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

Patient Phone Number: ____ - ____ - ____ **Patient Email:** _____

Patient Zip Code: _____

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 therapy support services. I may cancel this Authorization at any time by calling 1-833-AURINIA or mailing a letter to: Aurinia, 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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Patient Enrollment Form (continued)

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Patient Support Services: I authorize Aurinia to contact me to provide me support services related to any of Aurinia 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, Patient Support Services and agree to the terms.

Print 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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