Aurinia Alliance®

Patient Consent and Enrollment Form

Dedicated support, personalized for you.

Aurinia Alliance® is a program that provides personalized support through lupus nephritis education, tools, and resources. To enroll, complete this form and be sure to sign. **Bolded fields are required.**
You can submit your completed form by one of the following options:

Fax to Aurinia Alliance at 1-833-213-1001

Mail to PO Box 5490 Louisville, KY 40255

Email to Support@AuriniaAlliance.com

Scan here to complete this form online. Or visit www.auriniaalliance.com/enroll

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

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

Patient Phone # _____ - _____ - _____ **Patient Email:** _____

Patient Address: _____

Preferred Spoken Language: _____

Health Care Provider (prescriber) Name: _____ **Health Care Provider Phone Number:** _____

Please specify any authorized representatives with whom Aurinia Alliance is allowed to discuss your information:

Authorized Representative Name: _____ Phone Number: _____

Relationship to Patient: _____

By signing here, I consent to the Patient Support Services language and the Authorization to Share Health Information language (on page 2) and agree to the terms.

Consent to 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. This program is intended for US residents (6 months or more), who are 18 years and older and have a US mailing address.

☐ **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.

Patient Name: _____ **Relationship:** _____

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

Aurinia™

Patient Consent and Enrollment Form Continued

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 cancelation 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.