RAYALDEE® (CALCIFEDIOL) EXTENDED-RELEASE 30 MCG CAPSULES SERVICE REQUEST FORM

FAX: 1-844-660-7083 PHONE: 1-844-414-OPKO (6756)

OPKO CONNECT

1. Patient Information

Please complete all fields to prevent any delays.

☐ New start to Rayaldee® therapy ☐ Existing patient on therapy

First Name | Last Name | SS # (Last 4 only)

☐ Male ☐ Female

Date of Birth (MM/DD/YYYY)

Address

City | State | ZIP

Cell Phone | Home Phone

Email Address:

Preferred Method of Contact: ☐ Cell Phone ☐ Home Phone ☐ Email

Preferred Time of Contact: ☐ Morning ☐ Afternoon ☐ Evening

Ok to leave a message: ☐ Yes ☐ No

Primary Language: ☐ English ☐ Spanish ☐ Other:_____

2. Insurance Information

Please include copies of both sides of all insurance plan cards.

Primary Insurance | Phone #

Policy Holder Name | Relationship to Patient

Insurance ID # | Group #

The undersigned patient hereby represents and warrants that:
I hereby authorize my health care provider's office to provide OPKO or its agents, contractors, and subcontractors with my private personal information including protected health information as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I also authorize OPKO or its agents, contractors, and subcontractors to maintain and use this information, including my name, date of birth, social security number, diagnosis, insurance information, or other relevant information in order to conduct benefit verifications, insurance research and coverage appeals on my behalf, to contact my physician and insurer(s) and to exchange information with them in connection with the above referenced services.
I also authorize OPKO or its agents, contractors, and subcontractors to communicate with me via the e-mail address provided for the purpose of providing me with information pertaining to my coverage for Rayaldee, my eligibility status for the support programs offered by OPKO, and/or to communicate the need for additional information needed to accurately assess any coverage or assistance available to me for Rayaldee through my insurance coverage or OPKO.

Patient Signature | **Date of Signature (MM/DD/YYYY)**

☐ **Opt out of email communications**

3. Prescriber Information

Specialty of Prescriber: ☐ Nephrologist ☐ PCP ☐ Endocrinologist ☐ Internist

First Name | Last Name

Practice Name | Office Contact

Address

City | State | ZIP

Phone | Fax

Preferred Time of Contact | Tax ID #

Medicaid Provider # | Medicare Provider #

State Medical License # | NPI #

4. Starter Dose Prescription

Dispense: Rayaldee 30 mcg | Quantity: 14 | Days' supply

Directions

Prescriber Signature | Date

5. New Prescription

Dispense: Rayaldee 30 mcg | Quantity | Days' supply

Number of refills | Directions

Prescriber Signature | Date

6. Clinical Information *Please include supporting clinical documentation.*

ICD-10 Code:

☐ (N25.81) Secondary hyperparathyroidism
☐ (N18.4) CKD stage 4
☐ (N18.3) CKD stage 3
☐ (E55.9) Vitamin D deficiency
☐ Other_____

Lab Values & dates:

25(OH)D_____|_____ (value | date)
eGFR_____|_____ (value | date)
Phosphorus_____|_____ (value | date)
PTH_____|_____ (value | date)
Calcium_____|_____ (value | date)

Therapies within the previous 6 months:

☐ Hectorol® (doxercalciferol)
☐ OTC Vitamin D_3
☐ OTC Vitamin D_2
☐ Prescription Vitamin D_2 (ergocalciferol)
☐ Rocaltrol® (calcitriol)
☐ Zemplar® (paricalcitol)

The undersigned, as treating physician, hereby represents and warrants that:
(i) This prescription is medically appropriate for this patient and I will be supervising this patient's treatments.
(ii) I understand that any medication to be provided to this patient by OPKO through any of the patient assistance programs is complimentary, provided at no cost and may not be resold or billed to third-party payers, returned for credit or otherwise be placed in the stream of commerce.
(iii) I certify and warrant that all information supplied to OPKO or its agents, contractors, and subcontractors in connection with this enrollment form is accurate and has been obtained pursuant to an appropriate and valid patient authorization allowing for the release, transfer, and use of such information by OPKO or its agents, contractors or sub-contractors in accordance with State and Federal law for verification and/or preauthorization of patient's benefits.

Prescriber Signature | **Date of Signature (MM/DD/YYYY)** | **NPI #**

OPKO RENAL