

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

FAX: 1-844-660-7083 | PHONE: 1-844-414-OPKO (6756)
E-MAIL: OPKOCONNECT@RXALLCARE.COM

OPKOCONNECT

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

Alternate Contact or Healthcare Proxy First Name, Last Name and Phone

E-mail Address: _____

Preferred Method of Contact: Cell Phone Home Phone Email Text

Preferred Time of Contact: Morning Afternoon Evening

Ok to leave a message: Yes No

Primary Language: English Spanish Other: _____

2. Patient Insurance Information

Attached is a copy of both sides of the patient's insurance card

Primary Insurance Phone #

Policy Holder Name Relationship to Patient

Insurance ID # Group #

3. Patient Clinical Information Please include supporting clinical documentation.

ICD-10 Code:

Please check box 1. or 2. below

1. (N18.3) CKD stage 3, (N25.81) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency

2. (N18.4) CKD stage 4, (N25.81) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency

Therapies within the previous 6 months:

Hectorol® (doxercalciferol)

No previous therapies

OTC Vitamin D₂

Rocaltrol® (calcitriol)

OTC Vitamin D₃

Prescription Vitamin D₂ (ergocalciferol)

Zemplar® (paricalcitol)

Lab Values & dates:

25(OH)D _____ Calcium _____
value date value date

4. Prescriber Information

Specialty of Prescriber:

Nephrologist PCP Endocrinologist Internist

First Name Last Name

Phone Fax

Practice Name Office Contact

Preferred Time of Contact

Address

NPI #

City State ZIP

5. New Prescription

Dispense: Rayaldee 30 mcg Quantity Days' supply

Number of refills Directions

Prescriber Signature Date

6. Pharmacy Information

Name

Address Phone Fax

City State ZIP

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.

(iv) I authorize the program on my behalf to convey this prescription to the dispensing pharmacy to the extent permitted under state law.

Prescriber Signature

Date of Signature (MM/DD/YYYY)

NPI #

OPKORENAL

RAYALDEE is a registered trademark of EirGen Pharma Ltd., Hectorol is a registered trademark of Genzyme Corporation, Rocaltrol is a registered trademark of Validus Pharmaceuticals LLC, and Zemplar is a registered trademark of AbbVie Inc. ©2021 OPKO Pharmaceuticals LLC. OP-US-0090-102016v.10