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

Image: Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency Ok to leave a message: Ok to leave a message: Primary Language: English Ok to leave a message: Primary Language: English City State ZIP Primary Insurance Policy Holder Name Insurance ID # State Contact or Healthcare Proxy: First Name, Last Name and Phone Insurance ID # State	
First Name Last Name SS # (Latl 4digts orb) Preferred Time of Contact: Dreferred Time of Contact:	
Instructions List Nume Date of Birth (MM/DD/YYYY) Ok to leave a message: Primary Language: English III Address 2. Patient Insurance Information 2. Patient Insurance Address Cell Phone Home Phone Policy Holder Name Insurance ID # Alternate Contact or Healthcare Proxy: First Name, Last Name and Phone Insurance ID # Alternate Contact or Healthcare Proxy: First Name, Last Name and Phone Insurance ID # Alternate Contact or Healthcare Proxy: First Name, Last Name and Phone Insurance ID # CD-10 Code: 25(OH)D lab value less than 30 in Places check box 1. or 2. below "Lab date up to 24 months old is and (ESS.9) Vitamin D deficiency 1. (NIB.3) CKD stage 3, (N2S.81) Secondary hyperparathyroidism, and (ESS.9) Vitamin D deficiency "Lab date up to 24 months old is 2. (NIB.4) CKD stage 4, (N2S.81) Secondary hyperparathyroidism, and (ESS.9) Vitamin D deficiency "Lab date up to 24 months old is Prescriber Information Specialty of Prescriber: Nephrologist PCP First Name Last Name Phone English Prescriber Information Specialty of Prescriber: Nephrologist PCP City State ZIP NPI # S. New Prescription G. Pharmacy	Cell Phone Home Phone Email Text
Male Permale Ok to leave a message: Driversy Language:] Morning □ Afternoon □Evening
Date of Birth (MM/DD/YYYY) Primary Language: English Di Address 2. Patient Insurance Information City State ZIP Cell Phone Home Phone Policy Holder Name Alternate Contact or Healthcare Proxy: First Name, Last Name and Phone Insurance ID # 3. Patient Clinical Information Insurance box 7, or 2, below Insurance ID # 1. (NI8.3) CKD stage 3, (N25.81) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency 25(OH)D lab value less than 30 r 2. (NI8.4) CKD stage 4, (N25.81) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency "Lab date up to 24 months old is 4. Prescriber Information Speciality of Prescriber: Nephrologist PCP First Name Last Name Phone Email Address Quantity Days' supply Name Number of refills Directions Address City Number of refills Directions Address City City Prescriber Signature (Substitution permitted) Date City City OR Prescriber Signature (Substitution permitted) Date City City OR Prescriber Signature (Substitution permitted)]Yes □No
Address Attached is a copy of both sides of City State ZIP Primary Insurance Policy Holder Name Alternate Contact or Healthcare Proxy: First Name, Last Name and Phone Insurance ID # 3. Patient Clinical Information Insurance ID # ICD 10 Code: 25(OH)D lab value less than 30 r Presse Check box 1. or 2. below . 1. (NI8.3) CKD stage 3, (N25.81) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency . 2. (NI8.4) CKD stage 4, (N25.81) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency . 4. Prescriber Information Specialty of Prescriber: . First Name Last Name Phone Practice Name Office Contact Email Address . . . City State ZIP . Number of refills Directions . . Number of refills Directions . . Prescriber Signature (Substitution permitted) Date . . OR Prescriber Signature (Substitution permitted) Date]Spanish □Other:
Address Attached is a copy of both sides of City State ZIP Cell Phone Home Phone Policy Holder Name Alternate Contact or Healthcare Proxy: First Name, Last Name and Phone Insurance ID # 3. Patient Clinical Information 25(OH)D lab value less than 30 r ICD-10 Code: Pressecriber Kos 1. or 2. below 'Lab date up to 24 months old is 1. (NI8.3) CKD stage 3, (N25.81) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency 'Lab date up to 24 months old is 2. (NI8.4) CKD stage 4, (N25.81) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency 'Lab date up to 24 months old is First Name Last Name Phone First Name Last Name Phone Practice Name Office Contact Email Address Preferred Time of Contact Imail Address Office Contact NPI # S. New Prescription 6. Pharmacy information Name Number of refills Directions Address Prescriber Signature (Substitution permitted) Date City OR Prescriber Signature (Substitution permitted) Date Orefored refinered anomal substrate of oregone sectored of	ation
Cell Phone Home Phone Policy Holder Name Alternate Contact or Healthcare Proxy: First Name, Last Name and Phone Insurance ID # S. Patient Clinical Information Insurance ID # ICD-10 Code: 25(OH)D lab value less than 30 r Please check box 7. or 2. below 1. (N18.3) CKD stage 3, (N25.81) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency *Lab date up to 24 months old is and (E55.9) Vitamin D deficiency 2. (N18.4) CKD stage 4, (N25.81) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency *Lab date up to 24 months old is First Name Last Name Phone Prescriber Information Speciality of Prescriber: Nephrologist PCP First Name Last Name Phone Practice Name Office Contact Email Address Preferred Time of Contact City State ZIP Number of refills Directions Address Prescriber Signature (Dispense as written) Date City OR Prescriber Signature (Substitution permitted) Date OR Prescriber Signature (Substitution permitted) Date OR Prescriber Signatu	
Alternate Contact or Healthcare Proxy: First Name, Last Name and Phone Insurance ID # 3. Patient Clinical Information 25(OH)D lab value less than 30 r ICD-10 Code: 25(OH)D lab value less than 30 r Please check box 1. or 2. below "Lab date up to 24 months old is 1. (N18.3) CKD stage 3, (N25.8) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency "Lab date up to 24 months old is 2. (N18.4) CKD stage 4, (N25.8) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency Image: Comparison of the C	Phone #
3. Patient Clinical Information ICD-10 Code: 25(OH)D lab value less than 30 r Please check box 1. or 2. below *Lab date up to 24 months old is 1. (N18.3) CKD stage 3, (N25.81) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency *Lab date up to 24 months old is 2. (N18.4) CKD stage 4, (N25.81) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency *Lab date up to 24 months old is 4. Prescriber Information Specialty of Prescriber: Nephrologist PCP First Name Last Name Phone Practice Name Office Contact Email Address Preferred Time of Contact City State ZIP NPI # 5. New Prescription S. Pharmacy Information Nam Number of refills Directions Address Prescriber Signature (Dispense as written) Date City OR Prescriber Signature (Substitution permitted) Date Directions Address City City or Code outwards as paperiode for the paperiode of the space of contacts and backer to code outwards and output of the state of contacts. City OR City or Code output of the state of contacts. City Directions<	Relationship to Patient
ICD-10 Code: 25(OH)D lab value less than 30 r Please check box 1, or 2, below "Lab date up to 24 months old is 1. (N18.3) CKD stage 4, (N25.81) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency "Lab date up to 24 months old is 2. (N18.4) CKD stage 4, (N25.81) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency Image: Check box 1, or 2, below 4. Prescriber Information Specialty of Prescriber: Nephrologist PCP En First Name Last Name Phone Preferred Time of Contact Email Address Preferred Time of Contact Email Preferred Time of Contact Image: Check box 1, or 2, below Nam S. New Prescription G. Pharmacy Information Nam Nam Nam Number of refills Directions Address City Nam Prescriber Signature (Dispense as written) Date City City Nam Number of refills Directions Address City Nam Prescriber Signature (Substitution permitted) Date City	Group #
ICD-10 Code: 25(OH)D lab value less than 30 r Please check box 1. or 2. below "Lab date up to 24 months old is 1. (N18.3) CKD stage 4, (N25.81) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency "Lab date up to 24 months old is 2. (N18.4) CKD stage 4, (N25.81) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency Image: Check box 1.00 months old is 4. Prescriber Information Specialty of Prescriber: Image: Check box 1.00 months old is First Name Last Name Phone Practice Name Office Contact Email Address Preferred Time of Contact Email City State ZIP NPI # Dispense: Rayaldee 30 mcg Quantity Days" supply Nam Number of refills Directions Address City OR City Date City City Prescriber Signature (Substitution permitted) Date City City City The exception is medically appropriate for the patient and I will be supervised to the supervised to	
Please check box 1. or 2. below 1. (NI8.3) CKD stage 3, (N25.81) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency *Lab date up to 24 months old is 2. (NI8.4) CKD stage 4, (N25.81) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency Nephrologist PCP En 4. Prescriber Information Specialty of Prescriber: Nephrologist PCP En First Name Last Name Phone Practice Name Office Contact Email Address Preferred Time of Contact Email City State ZIP NPI # 5. New Prescription 6. Pharmacy Information Name Number of refills Directions Address City Prescriber Signature (Dispense as written) Date City City OR The seculation permitted) Date City Prescriber Signature (Substitution permitted) Date City City The seculation of the subset of sub-the subset and and by supervising the subset substance persons is complementary provided at no cost and may no more sub-contactes the secure and subset substance persons is complementary provided at no cost and may no more sub-contactes the secure and substantian top (VPO) and the subset substant asstance persons is complementary provided at no cost and may no more sub-contactes the sub-cost and the subset	ng/mL:
and (E55.9) Vitamin D deficiency 2. (N18.4) CKD stage 4, (N25.81) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency 4. Prescriber Information Specialty of Prescriber: Image: Prescriber Information Office Contact Enail Enail Address Preferred Time of Contact City State ZIP Number of refills Directions Address Prescriber Signature (Dispense as written) Date City OR Prescriber Signature (Substitution permitted) Date Image: Prescriber Signature (Substitution permitted) Date City Image: Prescr	value date*
(NI8.4) CKD stage 4, (N25.81) Secondary hyperparathyroidism, and (E55.9) Vitamin D deficiency (E55	s acceptable
and (E55.9) Vitamin D deficiency 4. Prescriber Information Specialty of Prescriber: In Nephrologist Prescriber Information First Name Practice Name Office Contact Prescriber Time of Contact City State ZIP NPI # S. New Prescription Dispense: Rayaldee 30 mcg Quantity Days' supply Name Number of refills Directions Address Prescriber Signature (Dispense as written) Date OR Prescriber Signature (Substitution permitted) Date City Other substitution permitted) Date City Cuantity and warrat that all information supplet to the splent assistance programs is complimentary, provided at no cost and may remarked the splent assistance programs is complimentary, provided at no cost and may remarked the splent assistance programs is complimentary, provided at no cost and may remarked the splent assistance programs is complimentary, provided at no cost and may remarked the splent assistance programs is complimentary, provided at no cost and may remarked to react or output on the splent assistance programs is complimentary, provided at no cost and may remarked to restore or output on the splent assistance programs is complimentary, provided at no cost and may remarked to react or output on the splent assistance program is accurate and has been or entact or output on the splent assistance program is accurate and has been or entact or output on the splent assistance program or my behall to convey this prescription to the dispersing pharmacy to the extent permitted under state law.	
First Name Last Name Phone Practice Name Office Contact Email Address Preferred Time of Contact City State ZIP NPI # State ZIP S. New Prescription 6. Pharmacy Information Dispense: Rayaldee 30 mcg Quantity Days' supply Number of refills Directions Address Prescriber Signature (Dispense as written) Date City OR City Date City Prescribor Signature (Substitution permitted) Date City OR City of the patient and will be supervising this patient's treatments. Incomplementary, provided at no cost and may no cost and may no the dather and induce to be for the patient and will be supervising this patient's treatments. Inderstand that and information splead to OFKO the supervising this patient's treatments. City or the supervising this patient's treatments. Inderstand that and information splead to OFKO the supervising this patient's treatments. Prevention is medically appropriate for this patient and will be supervising this patient's treatments. Inderstand that and information splead to OFKO the supervising this patient's treatments. City or the supervision is neallowing the backet and or the supervision to be intervise tor the order and th	
First Name Last Name Phone Practice Name Office Contact Email Address Preferred Time of Contact City State ZIP NPI # State ZIP S. New Prescription 6. Pharmacy Information Dispense: Rayaldee 30 mcg Quantity Days' supply Number of refills Directions Address Prescriber Signature (Dispense as written) Date City OR City Date City Prescriber Signature (Substitution permitted) Date City OR City of the patient and full be supervising this patient's treatments. Indentification of the patient and full be supervising this patient's treatments. Inderstand that on the wide tob to be invested to the content by OPKO trongshare, or of the subtent actions or of the content or of the role on the supplied to OPKO or its agents, contractors, and subcontractors in connection with this encollinement form is accurate and has been on early and warrant that all information supplied to OPKO or its agents, contractors, in content or or of or or or or of content or or of or or or of or or or or of or or or or of or or of or or of or or of or or of o	ndocrinologist 🛛 Internist
Practice Name Office Contact Email Address Preferred Time of Contact City State ZIP NPI # 6. Pharmacy Information Dispense: Rayaldee 30 mcg Quantity Days' supply Number of refills Directions Address Prescriber Signature (Dispense as written) Date City OR City City Date Prescriber Signature (Substitution permitted) Date City The prescriber suppropriate for this patient and I will be scorevising this patient's treatments. Scoregament that all information springers. Prescriber Signature (Substitution permitted) Date City The prescription is medically appropriate for this patient and I will be scorevising this patient's treatments. The prescription is medically appropriate for this patient and I will be scorevising this patient's treatments. The prescription is medically appropriate for this patient and I will be scorevising this patient's treatments. The patient's treatments. The prescription is medically appropriate for this patient's contractors or sub-contractors in accordance with State and Federal I authorize the program on my behalf to convey this prescription to the dispersing pharmacy to the extent permitted under state law.	
Address Preferred Time of Contact City State ZIP NPI # State State 5. New Prescription 6. Pharmacy Information Dispense: Rayaldee 30 mcg Quantity Days' supply Number of refills Directions Address Prescriber Signature (Dispense as written) Date City OR Prescriber Signature (Substitution permitted) Date Inderstight of the release, transfer, and use of such information by OPKO or its agents, contractors in accordance with State and Federal I authorization allowing for the release, transfer, and use of such information by OPKO or its agents, contractors in accordance with State and Federal I authorize the program on my behalf to convey this prescription to the extent permitted under state law.	Fax
City State ZIP NPI # 5. New Prescription G. Pharmacy Information Dispense: Rayaldee 30 mcg Quantity Days' supply Address Number of refills Directions Address Prescriber Signature (Dispense as written) Date City OR Prescriber Signature (Substitution permitted) Date Prescriber Signature (Substitution permitted) Date City City array City of the patient and like supervising this patients treatments. City of the patient assistance programs is complimentary, provided at no cost and may no array for credit or otherwise be placed in the stream of commerce. Citry inderstand thar any medicably appropriate for this patient by OPKO through any of the patient assistance programs is complimentary, provided at no cost and may no array for credit or otherwise be placed in the stream of commerce. Citry inderstand thar any medicably appropriate to PKPO or its agents, contractors in connection with this enrollment form is accurate and has been o intert authorize the program on my behalf to CPKO or its agents, contractors or sub-contractors in accordance with State and Pederal I authorize the program on my behalf to convey this prescription to the dispensing pharmacy to the extent permitted under state law.	
5. New Prescription 6. Pharmacy Information Dispense: Rayaldee 30 mcg Quantity Days' supply Nam Number of refills Directions Address Prescriber Signature (Dispense as written) Date City OR Prescriber Signature (Substitution permitted) Date This prescriber Signature (Substitution permitted) Date City Inderstand that any medication to be provided to this patient of thy option to be supervising this patient's treatments. Inderstand that any medication to be provided to this patient of VORO through any of the patient assistance programs is complimentary, provided at no cost and may not made or continue to a therwise be placed in the stream of commerce. I certify and warrant that all information supplied to OPKO or its agents, contractors in connection with this enrollment form is accurate and has been o ent 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 I I authorize the program on my behalf to convey this prescription to the dispensing pharmacy to the extent permitted under state law.	
Dispense: Rayaldee 30 mcg Quantity Days' supply Name Number of refills Directions Address Prescriber Signature (Dispense as written) Date City OR Prescriber Signature (Substitution permitted) Date Prescriber Signature (Substitution permitted) Date City Prescriber Signature (Substitution permitted) Date Date Indersigned, as treating physician, hereby represents and warrants that: This prescription is medically appropriate for this patient and I will be supervising this patient's treatments. Indersigned, as treating physician, hereby represents and warrants that: Indersigned, as treating physician, hereby represents and warrants that: This prescription is medically appropriate for this patient and I will be supervising this patient's treatments. Indersigned, as treating physician, hereby represents and warrants 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 no mered for credit or otherwise be placed in the stream of commerce. Icertify and warrant that all information supplied to OPKO or its agents, contractors in connection with this enrollment form is accurate and has been or lengt authorization allowing for the release, transfer, and use of such information by OPKO or its agents, contractors or sub-contractors accordance with State and Federal I authorize the program on my behalf to convey this prescription to the dispensing pharmacy to the extent permitted under state law.	
Number of refills Directions Address Prescriber Signature (Dispense as written) Date City OR Prescriber Signature (Substitution permitted) Date e undersigned, as treating physician, hereby represents and warrants that: City This prescription is medically appropriate for this patient and I will be supervising this patient's treatments. Complexity of the patient and I will be supervising this patient assistance programs is complimentary, provided at no cost and may no uned for credit or otherwise be placed in the stream of commerce. 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 or interactional lowing for the release, transfer, and use of such information by OPKO or its agents, contractors or sub-contractors in accordance with State and Federal I authorize the program on my behalf to convey this prescription to the dispensing pharmacy to the extent permitted under state law.	
Prescriber Signature (Dispense as written) Date OR City Prescriber Signature (Substitution permitted) Date e undersigned, as treating physician, hereby represents and warrants that: Experimentation of this patient by OPKO through any of the patient streatments. 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 may do arread that any medication to be provided to OPKO or its agents, contractors, and subcontractors or sub-contractors in accordance with State and Federal II authorize the program on my behalf to convey this prescription to the dispensing pharmacy to the extent permitted under state law.	ne
Prescriber Signature (Dispense as written) Date OR Prescriber Signature (Substitution permitted) Date e undersigned, as treating physician, hereby represents and warrants that: This prescription is medically appropriate for this patient and I will be supervising this patient's treatments. 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 no urned for credit or otherwise be placed in the stream of commerce. I certify and warrant that all information supplied to OPKO or its agents, contractors, and subcontractors in accordance with State and Federal I Tauthorize the program on my behalf to convey this prescription to the dispensing pharmacy to the extent permitted under state law.	Phone Fax
OR Prescriber Signature (Substitution permitted) Date undersigned, as treating physician, hereby represents and warrants that: This prescription is medically appropriate for this patient and I will be supervising this patient's treatments. I understand that any medication to be provided to this patient and I will be supervising this patient's treatments. I understand that any medication to be provided to this patient and I will be supervising this patient's treatments. I understand that any medication to be provided to this patient and I will be supervising this patient's treatments. I understand that any medication to be provided to this patient and I will be supervising any of the patient assistance programs is complimentary, provided at no cost and may not meed for credition or otherwise be placed in the stream of commerce. I certify and warrant that all information supplied to OPKO or its agents, contractors in connection with this enrollment form is accurate and has been o ent 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 II authorize the program on my behalf to convey this prescription to the dispensing pharmacy to the extent permitted under state law.	State ZIP
Prescriber Signature (Substitution permitted) Date audersigned, as treating physician, hereby represents and warrants that: This prescription is medically appropriate for this patient and I will be supervising this patient's treatments. 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 rired for credit or otherwise be placed in the stream of commerce. I certify and warrant that all information supplied to OPKO or its agents, contractors, and subcontractors or sub-contractors in accordance with State and Federal I authorize the program on my behalf to convey this prescription to the dispensing pharmacy to the extent permitted under state law.	
e undersigned, as treating physician, hereby represents and warrants that: This prescription is medically appropriate for this patient and I will be supervising this patient's treatments. 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 no rned for credit or otherwise be placed in the stream of commerce. 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 o I certify and warrant that all information autor due of such information by OPKO or its agents, contractors or sub-contractors and accordance with State and Federal I I authorize the program on my behalf to convey this prescription to the dispensing pharmacy to the extent permitted under state law.	
Prescriber Signature (MM/DD/YYYY)	obtained pursuant to an appropriate and valid
Prescriber Signature (MM/DD/YYYY)	
	NPI #



() (i (ii (iv

Rayaldee* is a registered trademark of Eirgen Pharma Ltd. OPKO Renal is a division of OPKO Health, Inc. © 2023 OPKO Pharmaceuticals, LLC. All rights reserved. OP-US-0090-042023v.11

