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

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 digits 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

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

25(OH)D lab value less than 30 ng/mL: _____|_____
value date*

*Lab date up to 24 months old is acceptable

4. Prescriber Information

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

First Name | Last Name

Practice Name | Office Contact

Address

City | State | ZIP

Phone | Fax

Email

Preferred Time of Contact

NPI #

5. New Prescription

Dispense: Rayaldee 30 mcg | Quantity | Days' supply

Number of refills | Directions

Prescriber Signature (Dispense as written) | Date

OR

Prescriber Signature (Substitution permitted) | 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 #**

OPKO RENAL