Labcorp Specialty Pharmacy
100 Technology Park, Suite 158, Lake Mary, FL 32746
Phone: 1-866-842-2147 **Fax**: 1-866-842-1509

Otsuka PATIENT ASSISTANCE FOUNDATION

VITAMINS REQUEST FORM

PRESCRIBER INFORMATION:

Date: (mm/dd/yyyy): _____

To the Prescribing Office of: _____

Tax ID #: _____ NPI #: _____ DEA #: _____

Fax Number: _____

Patient First Name: _____ Patient Last Name: _____

Patient DOB (mm/dd/yyyy): _____

MESSAGE:

We are the dispensing pharmacy for the Otsuka Patient Assistance Foundation, Inc (OPAF). The patient indicated above has been approved to receive free Nature Made® vitamins in addition to their free Otsuka medication. In order to dispense, we will need a prescription from you sent to Labcorp Specialty Pharmacy. Please fill out the following information and sign at the bottom if you wish to have your patient on any of these vitamin options.

VITAMINS:

*** Prescribers may check off multiple options. By checking an item, the prescriber authorizes the pharmacy to dispense this medication. ***

☐	Biotin 2500 mcg	*Take one capsule daily*	Qty:	90	Refills:	
☐	Calcium 600mg (w/ 10 mcg VitD)	*Take one softgel daily*	Qty:	100	Refills:	
☐	Fish Oil 1200 mg (720mg Omega 3)	*Take one capsule daily*	Qty:	100	Refills:	
☐	Folic Acid 400 mcg	*Take one tablet daily*	Qty:	250	Refills:	
☐	Iron 65mg (325 Ferrous Sulfate)	*Take one tablet daily*	Qty:	180	Refills:	
☐	Multi-Vitamin (Multi Complete)	*Take one tablet daily*	Qty:	130	Refills:	
☐	Super B - Complex	*Take one tablet daily*	Qty:	140	Refills:	
☐	Vitamin A 2400 mcg (8000 IU)	*Take one capsule daily*	Qty:	100	Refills:	
☐	Vitamin B1 100 mg	*Take one tablet daily*	Qty:	100	Refills:	
☐	Vitamin B6 100 mg	*Take one tablet daily*	Qty:	100	Refills:	
☐	Vitamin B12 1000 mcg	*Take one capsule daily*	Qty:	90	Refills:	
☐	Vitamin C 1000 mcg (Chewable)	*Take one tablet daily*	Qty:	90	Refills:	
☐	Vitamin C 1000 mg	*Take one tablet daily*	Qty:	100	Refills:	
☐	Vitamin D 50 mcg (2000 IU)	*Take one tablet daily*	Qty:	100	Refills:	
☐	Vitamin E 180 mg (400 IU)	*Take one capsule daily*	Qty:	100	Refills:	

I appoint the Otsuka Patient Assistance Foundation (hereafter, referred to as OPAF) to convey this prescription to the dispensing pharmacy. I certify that therapy with the above-mentioned product is medically necessary for this patient and I have reviewed the current Prescribing Information for the prescribed product. I attest that I am not on the HHS/OIG List of Excluded Individuals and Entities and that I am presently authorized under state law to prescribe this medication. I authorize and appoint OPAF to convey on my behalf any prescription information delivered to the dispensing pharmacy. For the purposes of transmitting this prescription, I authorize OPAF and its affiliates as my agent for these limited purposes to forward this prescription electronically, or via fax, or via mail to the dispensing pharmacy. I certify that any medication received will be used only for the patient named on this application and will not be offered for sale, trade, or barter. I acknowledge that OPAF is a free goods, non-profit program that assists patients that have been approved for assistance by meeting specific criteria. I acknowledge, that at any time, I can change or withdraw this prescription on the patient's behalf due to the medical needs of the patient by calling 1-855-727-6274 or by sending a written notice to OPAF at Otsuka Patient Assistance Foundation Inc., PO Box 501878, San Diego, CA 92150-1878. I understand that OPAF may revise, change, or terminate programs at any time.

Licensed Prescriber Signature: Sign Here _____ **Date**: _____

 Confidential-Protected Health Information June 2022 PAUS22EUP0005