OTSUKA PATIENT ASSISTANCE FOUNDATION, INC.
PO Box 4530, Chesterfield, MO 63006
PHONE: 1-855-727-6274; **FAX**: 1-844-727-6274

VITAMIN REQUEST FORM

PRESCRIBER INFORMATION:

Date: (mm/dd/yyyy): _____

To the Prescribing Office of: _____

NPI #: _____ 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 an order from you sent to **Eversana Life Science Services.** 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:

Note: Prescribers may check off multiple options.

☐ Biotin 2500 mcg	☐ Vitamin B1 100 mg
☐ *Calcium 600 mg	☐ Vitamin B6 100 mg
☐ Omega 1200 mg	☐ Vitamin B12 1000 mcg
☐ Folic Acid 400 mcg	☐ Vitamin C 1000 mcg (Chewable)
☐ Iron 65 mg (325 Ferrous Sulfate)	☐ Vitamin C 1000 mg
☐ Multi-Vitamin (Multi Complete)	☐ Vitamin D 50 mcg (2000 IU)
☐ Super B - Complex	☐ Vitamin E 180 mg (400 IU)
☐ Vitamin A 2400 mcg (8000 IU)	

*** Calcium 600 mg or 500 mg, depending on availability**

I appoint the Otsuka Patient Assistance Foundation (hereafter, referred to as OPAF) to convey this order 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 Label Information for the ordered 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 order this medication. I authorize and appoint OPAF to convey on my behalf any order information delivered to the dispensing pharmacy. For the purposes of transmitting this order, I authorize OPAF and its affiliates as my agent for these limited purposes to forward this order electronically, or via fax, or via mail to the dispensing pharmacy. I certify that any vitamins 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 order 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 4530, Chesterfield, MO 63006. I understand that OPAF may revise, change, or terminate programs at any time.

Prescriber's Name: _____

Sign here _____ **Date:** (mm/dd/yyyy) _____

 Confidential-Protected Health Information August 2023 PAUS23EUP0015