

**OSTEOPOROSIS  
REFERRAL FORM**  
Fax: 270-247-6033  
or 270-251-3571



**DUNCAN**  
SPECIALTY PHARMACY

317 W. Broadway  
Mayfield, KY 42066

Phone: 270-247-3725

Today's Date:

Needs by Date:

Ship to:  Patient  Office  Other:

**Patient Information**

Patient Name:

Address:

City, State, Zip:

Home & Cell #:

SSN:

DOB:

Sex:

Drug Allergies:

**Prescriber Information**

Prescriber Name:

Address:

City, State, Zip:

DEA #:

State Lic#:

NPI#:

Phone:

Fax:

Contact Person:

**INSURANCE INFORMATION: Please fax front & back copy of Medical & Prescription card(s) if possible:**

**Clinical Information—Statement Of Medical Necessity**

**Diagnostic Information & Prior Treatment History**

Diagnosis:

ICD-10 code(s):

T-Score:

Type:

Date:

Fracture History: Date/Site:

Date/Site:

Date/Site:

10 year Fracture Risk (%):

PREVIOUS MEDICATION(S)	DURATION/REASON FOR D/C

**Prescription Information**

<input type="checkbox"/>	MEDICATION	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/>	FORTEO <input type="checkbox"/> 600mg/2.4mL	<input type="checkbox"/> Inject 20mcg SQ once daily as directed	1 pen	
<input type="checkbox"/>	BD Pen Needles (For Forteo) <input type="checkbox"/> Pen Needles	<input type="checkbox"/> For use with Forteo. Use as directed.	100	
<input type="checkbox"/>	PROLIA <input type="checkbox"/> 60mg PFS	<input type="checkbox"/> INITIAL: Inject 300mg SQ once weekly for 5 weeks	1 syringe	
<input type="checkbox"/>	RECLAST <input type="checkbox"/> 5mg/100mL			
<input type="checkbox"/>				
<input type="checkbox"/>				

Prescriber Signature: \_\_\_\_\_

Date: \_\_\_\_\_

By signing this form & utilizing our services, you are authorizing Duncan Specialty Pharmacy & its employees to serve as your prior authorization designated agent in dealing with medical & prescription insurance companies. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials to another pharmacy of the patient's choice or within his/her provider network

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