DERMATOLOGY 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) as well as pertinent chart notes related to Patient's diagnosis.

Clinical Information—Statement Of Medical Necessity

Diagnostic Information

ICD-10 code(s): Diagnosis:
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ICD-10 code(s): Diagnosis:

Location: ☐Hands ☐Feet ☐Scalp ☐Groin ☐Nails ☐Other:

% BSA: _____ % TB/PPD Test Date Given:_____Results: ☐Negative ☐Positive (Please attach results)

Prior Treatment History

MEDICATION	DURATION/REASON FOR D/C	MEDICATION	DURATION/REASON FOR D/C
☐Methotrexate			
☐Cyclosporine		☐Topicals (list):	
☐Sulfasalazine			
☐Acitretin		☐Other:	
☐Biologics:			

Prescription Information

✓	MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
☐	COSENTYX	☐150mg Sensoready® Pen ☐150mg Prefilled Syringe	☐Induction: Inject 300mg SQ at Weeks 0, 1, 2, 3, and 4 ☐Maintenance: Inject 300mg SQ every 4 weeks		
☐	DUPIXENT	☐300mg Prefilled Syringe	☐Initial dose of 600mg, followed by 300mg every other week		
☐	ENBREL	☐50mg Sureclick ☐50mg Prefilled Syringe	☐Induction: Inject 50mg SQ twice weekly for 3 months then maintenance dose ☐Maintenance: Inject 50mg SQ weekly		
		☐25mg Vial Kit ☐25mg Prefilled Syringe	☐Inject 25mg SQ twice weekly ☐Other:_____		
☐	HUMIRA	☐Psoriasis Starter Kit ☐40mg Pen ☐40mg Prefilled Syringes	☐Psoriasis Induction: Inject 80mg SQ on Day 1, then 40mg every other week starting on Day 8 ☐Psoriasis Maintenance: Inject 40 mg SQ every other week. ☐HS Induction: Inject 160mg SQ on Day 1, then 80mg on Day 15, maintenance dose on Day 15 ☐HS Maintenance: Inject 40mg SQ once a week		
☐	OTEZLA	☐30mg Tablet	☐Take 1 tablet twice a day		
☐	SILIQ	☐210mg Prefilled Syringe	☐Induction: Inject 210mg SQ at Weeks 0, 1, and 2 ☐Maintenance: Inject 210mg SQ every 2 weeks		
☐	SIMPONI	☐50mg SmartJect ☐50mg Prefilled Syringe	☐Inject 50mg SQ once a month as directed		
☐	STELARA	☐45mg Prefilled Syringe ☐90mg Prefilled Syringe	☐<100kg Body Weight: Inject 45mg on day 0, week 4, & then every 12 weeks. ☐>100kg Body Weight: Inject 90mg on day 0, week 4, & then every 12 weeks.		
☐	TALTZ	☐80mg/mL Prefilled Syringe ☐80mg/mL Autoinjector	☐Inject 160mg SQ at Week 0; then 80mg for weeks 2, 4, 6, 8, 10, 12; then 80 mg every 4 weeks thereafter.		
☐	TREMFYA	☐100mg Prefilled Syringe	☐Inject 100mg SQ at Week 0, Week 4, and every 8 weeks thereafter.		

REVISED 08/03/2018

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.