RHEUMATOLOGY
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	Prescriber Information
Patient Name:	Prescriber Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Home & Cell #:	DEA #: State Lic#:
SSN:	NPI#:
DOB: Sex:	Phone: Fax:
Drug Allergies:	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

TB/PPD Test: ☐ Negative ☐ Positive **Please send a copy of TB/PPD Test Results**

ICD-10 code(s): Diagnosis:

ICD-10 code(s): Diagnosis:

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

Prescription Information

✓	MEDICATION		DIRECTIONS	QTY	REFILLS
☐	ACTEMRA	☐ 162mg Pre-filled Syringe	☐ Inject SQ once every week ☐ Inject SQ once every other week		
☐	CIMZIA	☐ Pre-filled Syringe	☐ INITIAL: Inject 400mg SQ at Day 1, Day 14, & Day 28 (qty:6) ☐ MAINTENANCE: Inject 400mg SQ every 4 weeks ☐ MAINTENANCE: Inject 200mg SQ every other week		
☐	COSENTYX	☐ 150mg Sensoready® Pen ☐ 150mg Prefilled Syringe	☐ INITIAL: Inject 300mg SQ qw x 5 weeks ☐ INITIAL: Inject 150mg SQ qw x 5 weeks ☐ MAINTENANCE: Inject 300mg SQ q4w ☐ MAINTENANCE: Inject 150mg SQ q4w		
☐	ENBREL	☐ SureClick Pen ☐ Vials ☐ Pre-filled Syringe ☐ Mini with Autotouch	☐ Inject 50mg SQ once a week ☐ Inject 50mg SQ twice a week ☐ Inject 25mg SQ twice a week		
☐	HUMIRA	☐ Pen ☐ Pre-filled syringe	☐ Inject 40mg SQ once a week ☐ Inject 40mg SQ every other week		
☐	KINERET	☐ 100 mg Syringe	☐ Inject 1 syringe SQ once a day		
☐	ORENCIA	☐ Pre-filled syringe ☐ 125mg Clickject	☐ Inject 125 mg SQ once a week		
☐	OTEZLA	☐ 30mg Tablet	☐ Take 1 tablet twice a day		
☐	OTREXUP	☐ 10 mg Auto Inj. ☐ 12.5 mg Auto Inj. ☐ 15 mg Auto Inj. ☐ 17.5 mg Auto Inj. ☐ 20 mg Auto Inj. ☐ 22.5 mg Auto Inj. ☐ 25 mg Auto Inj.	☐ Inject _____mg SQ every week	4	
☐	RASUVO	☐ 7.5 mg Auto Inj. ☐ 10 mg Auto Inj. ☐ 12.5 mg Auto Inj. ☐ 15 mg Auto Inj. ☐ 17.5 mg Auto Inj. ☐ 20mg Auto Inj. ☐ 22.5 mg Auto Inj. ☐ 25 mg Auto Inj. ☐ 27.5 mg Auto Inj. ☐ 30 mg Auto Inj.	☐ Inject _____mg SQ every week	4	
☐	SIMPONI	☐ Smartject (pen) ☐ Pre-filled Syringe	☐ Inject 50mg SQ once a month		
☐	STELARA	☐ 45mg Pre-filled syringe ☐ 90mg Pre-filled syringe	☐ Inject SQ on day 0, then week 4, then every 12 weeks thereafter		
☐	TALTZ	☐ 80mg/mL Pre-filled syringe ☐ 80mg/mL Autoinjector	☐ Inject 160mg SQ at Week 0, then 80mg every 4 weeks thereafter		
☐	XELJANZ	☐ 5 mg Tablet	☐ Take 1 tablet twice a day		
☐	XELJANZ XR	☐ 11 mg Tablet	☐ Take 1 tablet daily		

Revised Date: 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