ORILISSA 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 #:	NPI #: DEA#:
Emergency Contact Name:	State License #:
Emergency Contact Phone #:	Nurse/Key Office Contact:
SSN:	Tax ID#:
DOB: Sex:	Phone: Fax:
Drug Allergies:	

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

Date of Diagnosis (or years with disease):

☐ Is the patient currently receiving treatment or previously been treated for the diagnosis indicated? ☐ YES ☐ NO

☐ Moderate to severe pain associated with endometriosis ICD-10 code(s):

☐ Other ICD-10 code(s):

Do any of the following apply to the patient?

☐ Moderate hepatic impairment (Child Pugh Class B)
☐ Severe hepatic impairment (Child Pugh Class C)
☐ Osteoporosis
☐ Dyspareunia
☐ Currently pregnant or pregnancy possible
☐ Postmenopausal

☐ Is the patient currently receiving treatment or previously been treated for the diagnosis indicated? ☐ YES ☐ NO

Prior Treatment History *(attach list if necessary)*

MEDICATION	DURATION/REASON FOR D/C	MEDICATION	DURATION/REASON FOR D/C
☐ NSAIDs		☐ Synarel	
☐ Oral Contrceptives		☐ Zoladex	
☐ Lupron		☐ Other:	

☐ Does the patient have any contraindications or intolerances to any medications? ☐ YES ☐ NO

If yes, please name medication(s) and describe contraindication(s) or reaction(s):

Prescription Information

✓	MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
☐	ORILISSA	☐ 150mg tablet	☐ Take 1 tablet (150mg) by mouth once daily		
		☐ 200mg tablet	☐ Take 1 tablet1 (200mg) by mouth twice daily		

CREATED 05/24/2019

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.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error & then destroy this document immediately.