



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: \_\_\_\_\_  
ICD-10 code(s): \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
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
<input type="checkbox"/> Methotrexate		<input type="checkbox"/> Topicals (list):	
<input type="checkbox"/> Cyclosporine		<input type="checkbox"/> Other:	
<input type="checkbox"/> Sulfasalazine			
<input type="checkbox"/> Acitretin			
<input type="checkbox"/> Biologics:			

**Prescription Information**

✓	MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/>	ILUMYA	<input type="checkbox"/> 100mg PFS	<input type="checkbox"/> Induction: Inject 100mg SQ at Weeks 0, 4, and every 12 weeks thereafter <input type="checkbox"/> Maintenance: Inject 100mg SQ every 12 weeks	<input type="checkbox"/> 1 Month <input type="checkbox"/> 3 Months <input type="checkbox"/> Other:	
<input type="checkbox"/>	OTEZLA	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 30mg Tablet	<input type="checkbox"/> Follow Starter Pack directions <input type="checkbox"/> Take 1 tablet twice a day	<input type="checkbox"/> 1 Month <input type="checkbox"/> 3 Months <input type="checkbox"/> Other:	
<input type="checkbox"/>	SILIQ	<input type="checkbox"/> 210mg PFS	<input type="checkbox"/> Induction: Inject 210mg SQ at Weeks 0, 1, and 2 <input type="checkbox"/> Maintenance: Inject 210mg SQ every 2 weeks	<input type="checkbox"/> 1 Month <input type="checkbox"/> 3 Months <input type="checkbox"/> Other:	
<input type="checkbox"/>	SIMPONI	<input type="checkbox"/> 50mg SmartJect <input type="checkbox"/> 50mg PFS	<input type="checkbox"/> Inject 50mg SQ once a month	<input type="checkbox"/> 1 Month <input type="checkbox"/> 3 Months <input type="checkbox"/> Other:	
<input type="checkbox"/>	SKYRIZI	<input type="checkbox"/> 75mg PFS	<input type="checkbox"/> Induction: Inject 150mg (2 syringes) SQ at Weeks 0, 4, & every 12 weeks thereafter <input type="checkbox"/> Maintenance: Inject 150mg (2 syringes) SQ every 12 weeks	<input type="checkbox"/> 1 Month <input type="checkbox"/> 3 Months <input type="checkbox"/> Other:	
<input type="checkbox"/>	STELARA	<input type="checkbox"/> 45mg PFS <input type="checkbox"/> 90mg PFS	<input type="checkbox"/> <100kg Body Weight: Inject 45mg on day 0, week 4, & then every 12 weeks. <input type="checkbox"/> >100kg Body Weight: Inject 90mg on day 0, week 4, & then every 12 weeks. <input type="checkbox"/> Maintenance: 1 syringe SQ every 12 weeks	<input type="checkbox"/> 1 Month <input type="checkbox"/> 3 Months <input type="checkbox"/> Other:	
<input type="checkbox"/>	TALTZ	<input type="checkbox"/> 80mg PFS <input type="checkbox"/> 80mg Autoinjector	<input type="checkbox"/> Inject 160mg SQ on Week 0, then inject 80mg at Weeks 2, 4, 6, 8, 10, & 12 <input type="checkbox"/> Maintenance: Inject 80mg SQ every 4 weeks	<input type="checkbox"/> 1 Month <input type="checkbox"/> 3 Months <input type="checkbox"/> Other:	
<input type="checkbox"/>	TREMFYA	<input type="checkbox"/> 100mg PFS	<input type="checkbox"/> Induction: Inject 100mg SQ at Week 0, Week 4, and every 8 weeks thereafter. <input type="checkbox"/> Maintenance: Inject 100mg SQ every 8 weeks	<input type="checkbox"/> 1 Month <input type="checkbox"/> 3 Months <input type="checkbox"/> Other:	

Revised 07/12/2019

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.  
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