



DUNCAN

SPECIALTY PHARMACY

IUD Prescription Request Form

Fax: 270-251-3571

270-247-6033

Phone: 270-247-3725

Web: www.duncanrxcenter.com

DEMOGRAPHIC INFORMATION

Patient Name:		DOB:	
Patient Address:		City:	State: Zip Code:
Phone:		SSN:	
Prescriber Name:		Practice Name:	License #:
DEA #:	NPI #:	Office Fax:	
Prescriber Address:		City:	State: Zip Code:
Office Contact Person:		Office Contact Phone:	Office Contact Email:
Ship to address (If different than above):			

RX INSURANCE INFORMATION

Providing this information will help us to fulfill your request faster

Carrier Name:	_____	
Rx BIN:	_____	Rx ID: _____
Rx PCN:	_____	Rx Group: _____

PRESCRIPTION INFORMATION (Please mark)

	Product Name	Qty	SIG	Requested Delivery Date	Scheduled Placement Date
<input type="checkbox"/>	LILETTA	1	To be inserted by prescriber		
<input type="checkbox"/>	KYLEENA	1	To be inserted by prescriber		
<input type="checkbox"/>	MIRENA	1	To be inserted by prescriber		
<input type="checkbox"/>	PARAGARD	1	To be inserted by prescriber		
<input type="checkbox"/>	SKYLA	1	To be inserted by prescriber		

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. Revised 10/02/2018

Prescriber Signature: _____ Date: _____

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