

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: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	**Please send a copy of TB/PPD Test Results**
ICD-10 code(s): _____	Diagnosis: _____
ICD-10 code(s): _____	Diagnosis: _____
ICD-10 code(s): _____	Diagnosis: _____
ICD-10 code(s): _____	Diagnosis: _____

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

Prescription Information

✓	MEDICATION	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/>	ACTEMRA <input type="checkbox"/> 162mg Pre-filled Syringe	<input type="checkbox"/> Inject SQ once every week <input type="checkbox"/> Inject SQ once every other week	<input type="checkbox"/> 1 Month <input type="checkbox"/> 3 Months <input type="checkbox"/> Other:	
<input type="checkbox"/>	CIMZIA <input type="checkbox"/> Starter Kit <input type="checkbox"/> 200mg/mL Pre-filled Syringe (PFS)	Induction Dosing: <input type="checkbox"/> Inject 400mg SQ at Day 1, Day 14, & Day 28 (qty:6) Maintenance Dosing: <input type="checkbox"/> Inject 400mg SQ every 4 weeks <input type="checkbox"/> Inject 200mg SQ every other week	<input type="checkbox"/> 1 Month <input type="checkbox"/> 3 Months <input type="checkbox"/> Other:	
<input type="checkbox"/>	COSENTYX <input type="checkbox"/> 150mg Sensoready® Pen <input type="checkbox"/> 150mg PFS	Induction Dosing: <input type="checkbox"/> Inject 150mg SQ at Weeks 0, 1, 2, 3, and 4 <input type="checkbox"/> Inject 300mg SQ at Weeks 0, 1, 2, 3, and 4 Maintenance Dosing: <input type="checkbox"/> Inject 150mg SQ every 4 weeks <input type="checkbox"/> Inject 300mg SQ every 4 weeks	<input type="checkbox"/> 1 Month <input type="checkbox"/> 3 Months <input type="checkbox"/> Other:	
<input type="checkbox"/>	ENBREL <input type="checkbox"/> 25mg PFS <input type="checkbox"/> 25mg Vial <input type="checkbox"/> 50mg Mini Cartridge <input type="checkbox"/> 50mg PFS <input type="checkbox"/> 50mg SureClick Pen	<input type="checkbox"/> Inject 50mg SQ once a week <input type="checkbox"/> Inject 50mg SQ twice a week for 3 months, then 50mg SQ once a week. <input type="checkbox"/> Inject 25mg SQ once a week <input type="checkbox"/> Inject 25mg SQ twice a week <input type="checkbox"/> Inject 0.8mg/kg SQ once a week. Weight: _____ kg	<input type="checkbox"/> 1 Month <input type="checkbox"/> 3 Months <input type="checkbox"/> Other:	
<input type="checkbox"/>	HUMIRA <input type="checkbox"/> 40mg/0.4mL Citrate-Free Syringe <input type="checkbox"/> 40mg/0.4mL Citrate-Free Pen <input type="checkbox"/> 40mg/0.8mL Pre-filled Syringe <input type="checkbox"/> 40mg/0.8mL Pre-filled Pen <input type="checkbox"/> 40mg/0.4mL Citrate-Free Pen Starter Pack <input type="checkbox"/> 40mg/0.8mL Pens Starter Pack <input type="checkbox"/> 80mg/0.8mL & 40mg/0.4mL Citrate-Free Starter Pack	<input type="checkbox"/> Inject 40mg SQ every week <input type="checkbox"/> Inject 40mg SQ every other week <input type="checkbox"/> Inject 80mg SQ on Day 1, then 40mg SQ on Day 8 and Day 22	<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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