RHEUMATOLOGY
REFERRAL FORM
Fax: 270-247-6033
or 270-251-3571

DUNCAN SPECIALTY PHARMACY

317 W. Broadway
Mayfield, KY 42066
Phone: 270-247-3725

PRODUCTS I-Z

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

Prescription Information

✓	MEDICATION		DIRECTIONS	QTY	REFILLS
☐	KEVZARA	☐ 150mg PFS ☐ 200mg PFS	☐ Inject 150mg SQ every 2 weeks ☐ Inject 200mg SQ every 2 weeks	☐ 1 Month ☐ 3 Months ☐ Other:	
☐	KINERET	☐ 100 mg PFS	☐ Inject 1 syringe SQ once a day ☐ Inject 1 syringe SQ every other day	☐ 1 Month ☐ 3 Months ☐ Other:	
☐	OLUMIANT	☐ 2mg Tablet	☐ Take 1 tablet daily	☐ 1 Month ☐ 3 Months ☐ Other:	
☐	ORENCIA	☐ 125mg PFS ☐ 125mg Clickject	☐ Inject 125 mg SQ once a week	☐ 1 Month ☐ 3 Months ☐ Other:	
☐	OTEZLA	☐ Starter Pack ☐ 30mg Tablet	☐ Follow Starter Pack directions ☐ Take 1 tablet twice a day	☐ 1 Month ☐ 3 Months ☐ Other:	
☐	SIMPONI	☐ 50mg Smartject ☐ 50mg PFS	☐ Inject 50mg SQ once a month	☐ 1 Month ☐ 3 Months ☐ Other:	
☐	STELARA	☐ 45mg PFS ☐ 90mg PFS	☐ <100kg Body Weight: Inject 45mg on day 0, week 4, & then every 12 weeks. ☐ >100kg Body Weight: Inject 90mg on day 0, week 4, & then every 12 weeks. ☐ Maintenance: 1 syringe SQ every 12 weeks	☐ 1 Month ☐ 3 Months ☐ Other:	
☐	TALTZ	☐ 80mg PFS ☐ 80mL Autoinjector	☐ Inject 160mg SQ at Week 0, then 80mg every 4 weeks thereafter ☐ Maintenance: Inject 80mg SQ every 4 weeks	☐ 1 Month ☐ 3 Months ☐ Other:	
☐	XELJANZ	☐ 5mg Tablet	☐ Take 1 tablet twice a day	☐ 1 Month ☐ 3 Months ☐ Other:	
☐	XELJANZ XR	☐ 11mg Tablet	☐ Take 1 tablet daily	☐ 1 Month ☐ 3 Months ☐ 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