BAXDELA
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 #: | 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

ICD-10 code(s): Diagnosis (include date):

ICD-10 code(s): Diagnosis (include date):

Culture Results (include date):

Patient Height: Patient Weight:

Has the patient received IV Baxdela? ☐ Yes ☐ No Date Received:

| PREVIOUS MEDICATION(S) | DURATION/REASON FOR D/C (Please include dates) |
|---|---|
| | |
| | |
| | |
| | |

### Prescription Information

| ✓ | MEDICATION | DOSAGE | DIRECTIONS | QTY | REFILLS |
|---|---|---|---|---|---|
| ☐ | BAXDELA | 450mg Tab | Take 1 tablet by mouth every 12 hours for _____ days | | |

09/23/2019

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