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

DUNCAN SPECIALTY PHARMACY

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

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) as well as pertinent chart notes related to Patient's diagnosis.

Clinical Information—Statement Of Medical Necessity

Diagnostic Information

ICD-10 code(s): Diagnosis:
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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
☐Methotrexate			
☐Cyclosporine		☐Topicals (list):	
☐Sulfasalazine			
☐Acitretin		☐Other:	
☐Biologics:			

Prescription Information

✓	MEDICATION	STRENGTH	DIRECTIONS		QTY	REFILLS
☐	CIMZIA	☐ Prefilled Starter Kit ☐ Prefilled Syringe (PFS)	Induction Dosing Maintenance	☐ Inject 400mg SQ at Day 1, Day 14, & Day 28 (qty:6) ☐ Inject 400mg SQ every 4 weeks ☐ Inject 200mg SQ every other week	☐ 1 Month ☐ 3 Months ☐ Other:	
☐	COSENTYX	☐150mg Sensoready® Pen ☐150mg PFS	Induction Dosing Maintenance	☐ Inject 150mg SQ at Weeks 0, 1, 2, 3, and 4 ☐ Inject 300mg SQ at Weeks 0, 1, 2, 3, and 4 ☐ Inject 150mg SQ every 4 weeks ☐ Inject 300mg SQ every 4 weeks	☐ 1 Month ☐ 3 Months ☐ Other:	
☐	DUPIXENT	☐ 200mg PFS ☐ 300mg PFS	☐ Initial dose of 400mg, followed by 200mg every other week ☐ Initial dose of 600mg, followed by 300mg every other week		☐ 1 Month ☐ 3 Months ☐ Other:	
☐	ENBREL	☐ 25mg PFS ☐ 25mg Vial ☐ 50mg Mini Cartridge ☐ 50mg PFS ☐ 50mg SureClick Pen	☐ Inject 50mg SQ once a week ☐ Inject 50mg SQ twice a week for 3 months, then 50mg SQ once a week. ☐ Inject 25mg SQ once a week ☐ Inject 25mg SQ twice a week ☐ Inject 0.8mg/kg SQ once a week. Weight:_____kg		☐ 1 Month ☐ 3 Months ☐ Other:	
☐	HUMIRA	☐ 40mg/0.4mL Citrate-Free Syringe ☐ 40mg/0.4mL Citrate-Free Pen ☐ 40mg/0.8mL Pre-filled Syringe ☐ 40mg/0.8mL Pre-filled Pen ☐ 40mg/0.4mL Citrate-Free Pen Starter Pack ☐ 40mg/0.8mL Pens Starter Pack ☐ 80mg/0.8mL & 40mg/0.4mL Citrate-Free Starter Pack	☐ Inject 40mg SQ every week ☐ Inject 40mg SQ every other week ☐ Inject 80mg SQ on Day 1, then 40mg SQ on Day 8 and Day 22 ☐ Inject 160mg SQ on Day 1, 80mg SQ on Day 15, then 40mg SQ every week beginning on Day 29		☐ 1 Month ☐ 3 Months ☐ Other:	

Revised 10/08/2019

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.