

OSTEOPOROSIS  
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**

Patient Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Home & Cell #: \_\_\_\_\_  
 SSN: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Drug Allergies: \_\_\_\_\_

**Prescriber Information**

Prescriber Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 DEA #: \_\_\_\_\_ State Lic#: \_\_\_\_\_  
 NPI#: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 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**

Diagnosis: \_\_\_\_\_ ICD-10 code(s): \_\_\_\_\_  
 T-Score: \_\_\_\_\_ Type: \_\_\_\_\_ Date: \_\_\_\_\_  
 Fracture History: Date/Site: \_\_\_\_\_ Date/Site: \_\_\_\_\_ Date/Site: \_\_\_\_\_  
 10 year Fracture Risk (%): \_\_\_\_\_

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

**Prescription Information**

✓	MEDICATION	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/>	FORTEO <input type="checkbox"/> 600mg/2.4mL	<input type="checkbox"/> Inject 20mcg SQ once daily as directed	1 pen	
<input type="checkbox"/>	BD Pen Needles (For Forteo) <input type="checkbox"/> Pen Needles	<input type="checkbox"/> For use with Forteo. Use as directed.	100	
<input type="checkbox"/>	PROLIA <input type="checkbox"/> 60mg PFS	<input type="checkbox"/> INITIAL: Inject 300mg SQ once weekly for 5 weeks	1 syringe	
<input type="checkbox"/>	RECLAST <input type="checkbox"/> 5mg/100mL			
<input type="checkbox"/>	TYMLOS <input type="checkbox"/> 1 Prefilled Pen	<input type="checkbox"/> Inject 80mcg SQ once daily as directed	1 pen	
<input type="checkbox"/>				

Revised 05/15/2018

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  
**IMPORTANT NOTICE:** This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error & then destroy this document immediately.