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

# DUNCAN SPECIALTY PHARMACY

1522 Cuba Road
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

TB/PPD Test: ☐ Negative ☐ Positive

ICD-10 code(s): Diagnosis:

ICD-10 code(s): Diagnosis:

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

### Prescription Information

| ✓ | MEDICATION | DOSAGE | DIRECTIONS | QTY | REFILLS |
|---|---|---|---|---|---|
| ☐ | | | | | |
| ☐ | | | | | |
| ☐ | | | | | |
| ☐ | | | | | |
| ☐ | | | | | |

Revised Date: 08/19/2019

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