CROHN'S/ULCERATIVE COLITIS 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:
Patient Weight: lbs or KG
Drug Allergies:

Prescriber Information

Prescriber Name:
Address:
City, State, Zip:
DEA #: State Lic#:
NPI#:
Phone: Fax:
Contact Person Name:
Contact E-mail:

INSURANCE INFORMATION: Please fax front & back copy of Medical & Prescription card(s) if possible as well as pertinent chart notes related to Patient's diagnosis.

Clinical Information—Statement Of Medical Necessity

Diagnostic Information & Prior Treatment History

ICD-10 code(s): Diagnosis:
ICD-10 code(s): Diagnosis:
TB skin test date and result:

PREVIOUS MEDICATION(S)	DURATION/REASON FOR DISCONTINUING

Prescription Information

✓	MEDICATION		DIRECTIONS	QTY	REFILLS
☐	CIMZIA	☐ 200mg STARTER kit ☐ 400mg kit	☐ INITIATION Dose—Inject 400mg subcutaneously at weeks 0, 2, & 4 ☐ MAINTENANCE Dose—Inject 400mg subcutaneously every 4 weeks		
☐	ENTYVIO	300mg Vial	☐ INTIATION Dose–Infuse 300mg intravenously over 30 minutes at weeks 0, 2, & 6 ☐ MAINTENANCE Dose–Infuse 300mg intravenously over 30 minutes every 8 Wks		
☐	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 160mg SQ on Day 1, 80mg SQ on Day 15, then 40mg SQ every week beginning on Day 29 ☐ Inject 160mg SQ on Day 1, 80mg SQ on Day 15, then 40mg SQ every other week beginning on Day 29		
☐	REMICADE	100mg (weight-based dosing)	☐ INITIATION Dose – Infuse 5mg/kg at Weeks 0, 2, and 6 ☐ MAINTENACE Dose – Infuse 5mg/kg every 8 weeks		
☐	SIMPONI	100mg Pen	☐ INITIATION Dose–Inject 200mg (2pens) SQ on Week 0, then 100mg (1pen) Week 2 ☐ MAINTENANCE Dose– Inject 100mg SQ every 4 weeks		
☐	STELARA	☐ 130mg IV (weight-based dosing) ☐ 90mg PFS	☐ INITIATION Dose – Inject a single intravenous infusion of: ☐ ≤55kg: 260 mg (2 vials) ☐ 55kg—85kg: 390 mg (3 vials) ☐≥ 85 kg: 520 mg (4 vials) ☐ MAINTENANCE Dose – Inject 90 mg SQ every 8 weeks		
☐	XIFAXAN	550mg tablets	☐ Take 1 tablet 3 times a day		

Revised 05/18/2022

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

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