MULTIPLE SCLEROSIS 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	**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:
ICD-10 code(s): Diagnosis:
ICD-10 code(s): Diagnosis:
Single Demyelinating Episode (high risk): ☐Yes ☐No
Relapsing/Remitting Disease: ☐Yes ☐No
Secondary Progressive: ☐Yes ☐No

SYMPTOMS (Check All That Apply)

☐Tingling ☐Superimposed Relapses ☐Pain ☐Balance Disturbance
☐Numbness ☐Limb Weakness ☐Double Vision ☐Other:

Number of Documented MS Attacks

☐1-2 episodes ☐3-4 episodes ☐5-6 episodes ☐More than 7 episodes

MRI Evidence

☐Neurological Inflammation in 1 area of CNS ☐Neurological Inflammation in *more than 1* area of CNS ☐Demyelinated Lesions

Prescription Information

	MEDICATION	DOSE/FREQUENCY/ROUTE	QTY	REFILLS
☐	AVONEX			
☐	BETASERON			
☐	COPAXONE			
☐	EXTAVIA			
☐	REBIF			
☐	GILENYA			
☐				

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.

Prescriber Signature: _____ Date: _____