WOMENS' HEALTH 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

☐N80.0	Endometriosis of Uterus	☐N80.3	Endometriosis of Pelvic Peritoneum	☐N80.6	Endometriosis on Scar of Skin
☐N80.1	Endometriosis of Ovary	☐N80.4	Endometriosis of Rectovaginal Septum & Vagina	☐N80.8	Endometriosis of Unspecified
☐N80.2	Endometriosis of Fallopian Tube	☐N80.5	Endometriosis of Intestines	☐N80.9	Endometriosis of Site Specified
☐D25.9	Uterine Leiomyoma	☐292.0	Personal History of Contraception	☐B37.3	Candidiasis of vulva and vagina

Has patient had prior treatment for this diagnosis? ☐ Yes ☐ No

Dates of previous therapy and medication:

For Lupron Depot Prescriptions

Start Date: ☐ New to Lupron ☐ Restart ☐ Continuing

Date of Diagnosis:

Primary Diagnosis for which Lupron Depot is being prescribed: ☐ N80.9 Endometriosis ☐ D25.9 Fibroids ☐ Other: (Specify)

PRESCRIPTION INFORMATION

MEDICATION	DIRECTIONS	QTY	REFILLS
ENDOMETRIOSIS & UTERINE FIBROIDS			
☐ Lupron Depot 3.75 mg (1-month supply)	Administer IM once a month	1 Kit	
☐ Lupron Depot 11.25 mg (3-month supply)	Administer IM once every 3 months	1 Kit	
MEDICATION	DIRECTIONS	QTY	REFILLS
ADD-BACK THERAPY (ENDOMETRIOSIS ONLY)			
☐ Norethindrone Acetate 5mg Tablet	Take (1) tablet by mouth once a day	☐ 30 ☐ 90	
☐ Norethindrone Acetate 5 mg Tablet	Specify Directions:		
MEDICATION	DIRECTIONS	QTY	REFILLS
☐ Orilissa 150mg Tablet	Take (1) tablet by mouth once a day	28	
☐ Orilissa 200mg Tablet	Take (1) tablet by mouth twice a day	56	
☐ Myfembree 0.5mg Tablet	Take (1) tablet by mouth once a day	28	
☐ Medroxyprogesterone	Administer IM once every 3 months	1	
OTHER MEDICATIONS			
MEDICATION	DIRECTIONS	QTY	REFILLS
☐ Brexafemme 150 mg Tablet	Take (2) tablets by mouth every 12 hours x1 day	4	

REVISED 03/04/22. 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:** _____