IUD 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:
DOB:	Practice Name:
Address:	Prescriber Address:
City, State, Zip:	City, State, Zip:
	NPI#: State Lic#:
Home & Cell #:	DEA#:
SSN:	Office Contact Name:
Medicaid ID#:	Office Contact Phone: Fax:
Drug Allergies:	Contact Email:

Office Preferred Method of Contact: ☐ Fax ☐ Email ☐ Phone *(Please provide direct phone #):*

INSURANCE INFORMATION: Please fax front & back copy of Medical & Prescription card(s) if possible:

CLINICAL INFORMATION—STATEMENT OF MEDICAL NECESSITY

RX INSURANCE INFORMATION

Carrier Name:

Rx ID: **Rx Group:**

Rx BIN: **Rx PCN:**

ICD-10 CODE

☐ Z92.0 Personal History of Contraception ☐ T83.32 Displacement of Intrauterine Contraceptive Device

☐ N92.0 Excessive and Frequent Menstruation with Regular Cycle ☐ Other: _____

PRESCRIPTION INFORMATION

✓	PRODUCT	DIRECTIONS	QTY	REQUESTED DELIVERY DATE
☐	**LILETTA**	To be inserted by prescriber	1	
☐	**KYLEENA**	To be inserted by prescriber	1	
☐	**MIRENA**	To be inserted by prescriber	1	
☐	**PARAGARD**	To be inserted by prescriber	1	
☐	**SKYLA**	To be inserted by prescriber	1	
☐	**NEXPLANON**	To be inserted by prescriber	1	

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