BOTOX
REFERRAL FORM
FAX: 270-247-6033 OR
270-251-3571

DUNCAN
SPECIALTY PHARMACY

317 W. BROADWAY
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:
Patient Weight: lbs or KG	Contact Person:
Drug Allergies:	Contact Email:

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:
ICD-10 code(s):	Diagnosis:

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

Prescription Information

	MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
☐	BOTOX	100 units/vial	Inject every 3 months as directed.		
☐	BOTOX	200 units/vial	Inject every 3 months as directed.		

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: _____