OSTEOPOROSIS 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:
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

Diagnosis: ICD-10 code(s):

T-Score: Type: Date:

Fracture History: Date/Site: Date/Site: Date/Site:

10 year Fracture Risk (%):

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

Prescription Information

☐	MEDICATION		DIRECTIONS	QTY	REFILLS
☐	FORTEO	☐ 600mg/2.4mL	☐ Inject 20mcg SQ once daily as directed	1 pen	
☐	BD Pen Needles (For Forteo)	☐ Pen Needles	☐ For use with Forteo. Use as directed.	100	
☐	PROLIA	☐ 60mg PFS	☐ INITIAL: Inject 300mg SQ once weekly for 5 weeks	1 syringe	
☐	RECLAST	☐ 5mg/100mL			
☐					
☐					

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