MULTIPLE SCLEROSIS 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

ICD-10 code(s):	Diagnosis:	
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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: _____