

PRESCRIPTION FORM

Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

altScripts Specialty Pharmacy
 1636 Miller Park Way, West Milwaukee, WI 53214
 Phone: 414-385-9500 Fax: 414-385-7200
 www.altscripts.com



Patient Information: please provide a copy of the patient's insurance card or information					
Patient Name:		DOB:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M	HT:	WT:
Address:		City:	State:	Zip Code:	Phone:
Insurance:	Subscriber's name:		ID#:	Group #:	
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> List allergies:					
Clinical Information: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization					
Diagnosis / ICD-10:					
Prior Therapies:					
Prescription Information					
Medication	Dose / Strength	Directions	Quantity	Refills	
Physician Information					
Prescriber name:		Phone:	Office contact name:		
Prescriber address:		City:	State:	Zip:	
NPI:	DEA:		Fax and/or Email:		
Prescriber signature:		Date:	<input type="checkbox"/> DO NOT SUBSTITUTE		

Important Notice: This facsimile transmission is intended to be delivered only to the named recipient(s), and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named recipient, immediately notify the sender at the address and phone number set forth herein and obtain instructions as to properly dispose of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except authority of the sender to the named addressee.