CROHN'S DISEASE / ULCERATIVE COLITIS 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:** □ F □ M	**HT:**	**WT:**	
Address:	**City:**	**State:**	**Zip Code:**	**Phone:**	
Insurance:	**Subscriber's name:**	**ID#:**	**Group #:**		
Allergies: ☐ NKDA ☐ List allergies:					

Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization	
Diagnosis / ICD-10:	
TB Test/Date:	**Prior Therapies:**
□ **Patient is currently on therapy** (Start date ____/_____/_____)	

Crohn's Disease / Ulcerative Colitis

Medication	Dose / Strength	Directions	Quantity	Refills
☐ **Cimzia®**	□ Starter Kit	□ Inject SQ 400 mg days 0, 14, 28		
	□ 200 mg PFS	□ Inject SQ 400 mg every 28 days		
☐ **Humira®**	□ Starter Kit	□ Inject SQ 4 pens (160 mg) day 1; 2 pens (80 mg) day 15		
	□ 40 mg/ 0.8 ml pens	□ Inject SQ 1 pen (40 mg) every other week		
	□ 40 mg/ 0.8 ml PFS	□ Inject SQ		
☐ **Entyvio®**	□ 300 mg/ 20 ml vial	□ Infuse IV 300 mg weeks 0, 2, 6		
		□ Infuse IV 300 mg every 8 weeks		
☐ **Remicade®**	□ 100 mg/ 20 ml vial	□ Infuse IV 5 mg/ kg weeks 0, 2, 6		
		□ Infuse IV 5 mg/ kg every 8 weeks		
		□ Infuse IV		
☐ **Simponi®**	□ 100 mg/ ml Smartject® Autojector	□ Inject SQ 200 mg week 0; 100 mg weeks 2, 6		
	□ 100 mg/ ml PFS	□ Inject SQ 100 mg every 4 weeks		
☐ **Stelara®**	□ 90 mg/ ml PFS	□ Inject SQ 90 mg dose 8 weeks after the initial IV dose, then every 8 weeks thereafter **Date of initial IV dose**: _____		
☐ **Other**				

Physician Information				
Prescriber name:	**Phone:**	**Office contact name:**		
Prescriber address:	**City:**	**State:**	**Zip:**	
NPI:	**DEA:**	**Fax and/or Email:**		
Prescriber signature:	**Date:**	□ **DO NOT SUBSTITUTE**		