

# 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: <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 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:		
<input type="checkbox"/> Patient is currently on therapy (Start date ____/____/____)					
Crohn's Disease / Ulcerative Colitis					
Medication	Dose / Strength	Directions	Quantity	Refills	
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> Starter Kit <input type="checkbox"/> 200 mg PFS	<input type="checkbox"/> Inject SQ 400 mg days 0, 14, 28 <input type="checkbox"/> Inject SQ 400 mg every 28 days			
<input type="checkbox"/> Humira®	<input type="checkbox"/> Starter Kit <input type="checkbox"/> 40 mg/ 0.8 ml pens <input type="checkbox"/> 40 mg/ 0.8 ml PFS	<input type="checkbox"/> Inject SQ 4 pens (160 mg) day 1; 2 pens (80 mg) day 15 <input type="checkbox"/> Inject SQ 1 pen (40 mg) every other week <input type="checkbox"/> Inject SQ			
<input type="checkbox"/> Entyvio®	<input type="checkbox"/> 300 mg/ 20 ml vial	<input type="checkbox"/> Infuse IV 300 mg weeks 0, 2, 6 <input type="checkbox"/> Infuse IV 300 mg every 8 weeks			
<input type="checkbox"/> Remicade®	<input type="checkbox"/> 100 mg/ 20 ml vial	<input type="checkbox"/> Infuse IV 5 mg/ kg weeks 0, 2, 6 <input type="checkbox"/> Infuse IV 5 mg/ kg every 8 weeks <input type="checkbox"/> Infuse IV			
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 100 mg/ ml Smartject® Autojector <input type="checkbox"/> 100 mg/ ml PFS	<input type="checkbox"/> Inject SQ 200 mg week 0; 100 mg weeks 2, 6 <input type="checkbox"/> Inject SQ 100 mg every 4 weeks			
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 90 mg/ ml PFS	<input type="checkbox"/> Inject SQ 90 mg dose 8 weeks after the initial IV dose, then every 8 weeks thereafter Date of initial IV dose: _____			
<input type="checkbox"/> Other					
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.