

DERMATOLOGY 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	<input type="checkbox"/> Psoriasis / _____ <input type="checkbox"/> Psoriatic Arthritis / _____ <input type="checkbox"/> Chronic Idiopathic Urticaria / _____ <input type="checkbox"/> Hidradenitis Suppurativa / _____ <input type="checkbox"/> Acne / _____ <input type="checkbox"/> Other: _____				
PSO/PSA	Diagnosed with: <input type="checkbox"/> CHF <input type="checkbox"/> Latex Allergy <input type="checkbox"/> MS <input type="checkbox"/> Hep B/C <input type="checkbox"/> Malignancy			Affected areas: <input type="checkbox"/> palms <input type="checkbox"/> soles <input type="checkbox"/> head <input type="checkbox"/> neck <input type="checkbox"/> genitalia	
	TB/PPD test: Y / N Date of negative test: _____			% of BSA affected: _____	
	<input type="checkbox"/> Patient is currently on therapy (Start date ___/___/___) Prior Therapies: Please include biologics, MTX, PUVA, topicals, UVB/NBUVB and trials, including dates of treatment and reasons for discontinuation.				
CIU	Continuation of therapy with Xolair: Y / N (Start date ___/___/___)			Patient achieved adequate response to Xolair: Y / N	
	Prior Therapies: Please include H1 antihistamines, leukotriene blockers and combination therapy, including dates of treatment, dose & reason for discontinuation.				

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.