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: ☐ 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	☐ Psoriasis /_____ ☐ Psoriatic Arthritis / _____ ☐ Chronic Idiopathic Urticaria / _____ ☐ Hidradenitis Suppurativa / _____ ☐ Acne / _____ ☐ Other:	
PSO/PSA	**Diagnosed with:** ☐ CHF ☐ Latex Allergy ☐ MS ☐ Hep B/C ☐ Malignancy	**Affected areas:** ☐ palms ☐ soles ☐ head ☐ neck ☐ genitalia
	TB/PPD test: Y / N Date of negative test:	**% of BSA affected:**
	☐ **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:	☐ DO NOT SUBSTITUTE