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 / _____ ☐ 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.	

Atopic Dermatitis

Medication	Dose / Strength	Directions	Quantity	Refills
☐ **Dupixent®**	☐ 300 mg/2 mL solution in a single-dose pre-filled syringe with needle shield	☐ Initial dose of 600 mg (two 300 mg injections in different injection sites), followed by 300 mg given every other week.		

Psoriasis / Psoriatic Arthritis

Medication	Dose / Strength	Directions	Quantity	Refills
☐ **Cimzia®** (PSA)	☐ Starter Kit	☐ 400 mg SQ at Weeks 0, 2 and 4		
	☐ 200 mg/ ml prefilled syringe	☐ 200 mg SQ every 2 weeks		
	☐ 400 mg lyophilized vial	☐ 400 mg SQ every 4 weeks		
☐ **Cosentyx®** (PSO)	☐ 150 mg/ml single-use prefilled syringe ☐ 150 mg/ml Sensoready pen	☐ 300 mg SQ at Weeks 0, 1, 2, 3, and 4, followed by 300 mg every 4 weeks		
☐ **Enbrel®** (PSO/PSA)	☐ 25 mg/ml (latex free)	☐ 50 mg SQ twice weekly for 3 months		
	☐ 50 mg/ml SureClick® autoinjector ☐ 50 mg/ml prefilled syringe	☐ 50 mg SQ once weekly		
☐ **Humira®** (PSO/PSA)	☐ 40 mg/ 0.8 ml Starter Pack	☐ 80 mg SQ day 0; 40 mg day 7; then 40 mg every 14 days		
	☐ 40 mg/ 0.8 ml Pens ☐ 40 mg/ 0.8 ml prefilled syringe	☐ 40 mg SQ every other week		
☐ **Ilumya™** (PSO)	☐ 100 mg prefilled syringe	☐ 100 mg SQ at Weeks 0 and 4, then every 12 weeks.		
☐ **Otezla®** (PSO/PSA)	☐ Starter Kit	☐ Taper per starter pack packaging		
	☐ 30 mg tablets	☐ 30 mg PO twice daily		
		☐ 30 mg PO once daily		
☐ **Siliq™** (PSO)	☐ 210 mg/1.5 mL solution single-dose prefilled syringe	☐ 210 mg SQ at Weeks 0, 1, and 2, followed by 210 mg every 2 weeks thereafter		
☐ **Simponi®** (PSA)	☐ 50 mg/ 0.5 ml SmartJect® autoinjector ☐ 50 mg/ 0.5 ml prefilled syringe	☐ 50 mg SQ every 4 weeks		
	☐ 100 mg/ml SmartJect® autoinjector ☐ 100 mg/ml prefilled syringe	☐ 200 mg SQ day 0; 100 mg day 7; then 100 mg every 4 weeks		
☐ **Stelara®** (PSO/PSA)	☐ 45 mg/ 0.5 ml prefilled syringe	☐ Inject 45 mg SQ days 0, 28 and then every 12 weeks		
	☐ 90 mg/ 1 ml prefilled syringe	☐ Inject 90 mg SQ days 0, 28 and then every 12 weeks		
☐ **Taltz™** (PSO)	☐ 80 mg/mL prefilled syringe ☐ 80 mg/mL prefilled autoinjector	☐ 160 mg SQ (two 80 mg injections) at Week 0, followed by 80 mg at Weeks 2, 4, 6, 8, 10, and 12, then 80 mg every 4 weeks		
☐ **Tremfya™** (PSO)	☐ 100 mg/mL prefilled syringe	☐ 100 mg SQ at Weeks 0 and 4, and every 8 weeks thereafter		

Hidradenitis Suppurativa (HS)

Medication	Dose / Strength	Directions	Quantity	Refills
☐ **Humira®**	☐ Starter Kit	Inject 4 pens (160 mg), as ☐ four 40 mg SQ injections on Day 1 OR ☐ two 40 mg SQ injections per day on Days 1 and 2; 2 pens (80 mg) day 15	☐ 28 days supply	
	☐ 40 mg/ 0.8 ml pens	☐ Inject 1 pen (40 mg) SQ every week, two weeks later (day 29)		

Prescriber Information

Prescriber name:	Phone:	Office contact name:

Prescriber address:	City:	State:	Zip:

NPI:	DEA:	Email / Fax:

Signature:	Date:	☐ DO NOT SUBSTITUTE