GASTROENTEROLOGY 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 ____/_____/_______)	

Hepatic Encephalopathy / IBS-D / Traveler's Diarrhea

Medication	Strength	Directions	Quantity	Refills
□ Xifaxan®	☐ 200 mg ☐ 550 mg	☐ Take one 200 mg tablet by mouth three times a day for 3 days ☐ Take one 550 mg tablet by mouth two times a day ☐ Take one 550 mg tablet by mouth three times a day for 14 days		

Crohn's Disease / Ulcerative Colitis

Medication	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® - Citrate Free	☐ Starter Kit - 80mg / 0.8mL	☐ Inject 160 mg SQ day 1; 80 mg day 15; two weeks later (Day 29), begin a maintenance dose of 40 mg every other week		
	☐ 40 mg/ 0.4 mL pens or prefilled syringes	☐ Inject 40 mg SQ every other week		
☐ 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 ☐ 100 mg/ mL PFS	☐ Inject SQ 200 mg week 0; 100 mg weeks 2, 6 ☐ 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 **Date of initial IV dose**: ___________________________		
☐ Xeljanz®	☐ 5 mg tablet ☐ 10 mg tablet	☐ 10 mg twice daily for at least 8 weeks; then 5 or 10 mg twice daily. ☐ Other:		

□ 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	

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