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

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.	

Medication	Dose / Strength	Directions	Quantity	Refills
☐ Cimzia® (PSO/PSA)	☐ Starter Kit ☐ 200 mg/ mL prefilled syringe ☐ 400 mg lyophilized vial	☐ 400 mg SQ weeks 0, 2 and 4 ☐ 400 mg (given as 2 SQ inj of 200 mg each) every other week ☐ 200 mg SQ every 2 weeks ☐ 400 mg SQ every 4 weeks		
☐ Cosentyx® (PSO)	☐ 150 mg/ mL single-use prefilled syringe ☐ 150 mg/ mL Sensoready pen	☐ 300 mg SQ weeks 0, 1, 2, 3, and 4, then 300 mg every 4 weeks		
☐ Dupixent® (atopic dermatitis)	☐ 200 mg/ 1.14 mL solution in a single-dose pre-filled syringe with needle shield ☐ 300 mg/ 2 mL solution in a single-dose pre-filled SYRINGE with needle shield ☐ 300 mg/ 2 mL solution in a single-dose pre-filled PEN	☐ ADULTS: Initial dose of 600 mg (two 300 mg injections in different injection sites), then 300 mg every other week. ☐ _____KG PEDIATIC, 6 YRS & OLDER:		
☐ Enbrel® (PSO/PSA)	☐ 25 mg/ mL (latex free) ☐ 50 mg/ mL SureClick® autoinjector ☐ 50 mg/ mL prefilled syringe ☐ 50 mg/ mL solution in Enbrel MiniTM single-dose prefilled cartridge for use with the AutoTouch™ reusable autoinjector only	☐ 50 mg SQ twice weekly for 3 months ☐ 50 mg SQ once weekly ☐ Other:		
☐ Humira® - Citrate Free (Hidradenitis Suppurativa)	☐ Starter Kit - 80 mg / 0.8 mL ☐ 40 mg/ 0.4 mL pens or prefilled syringes ☐ 80 mg/ 0.8 mL pens	☐ Inject 160 mg SQ day 1; 80 mg day 15; two weeks later (day 29), begin a maintenance dose of 40 mg every week ☐ Inject 40 mg SQ weekly and repeat in two weeks ☐ Inject 1 pen (80 mg) SQ every two weeks and repeat in two weeks		
☐ Humira® - Citrate Free (PSO/PSA)	☐ Starter Kit - 80 mg / 0.8 mL and 40 mg / 0.4mL ☐ 40 mg/ 0.4 mL pens or prefilled syringes	☐ Initial dose of 80 mg SQ, followed by 40 mg every other week starting one week after initial dose ☐ 40 mg SQ every other week		
☐ Ilumya™ (PSO)	☐ 100 mg prefilled syringe	☐ 100 mg SQ day 0 and 28, then every 12 weeks.		
☐ Otezla® (PSO/PSA)	☐ Starter Kit ☐ 30 mg tablets	☐ Taper per starter pack packaging ☐ 30 mg PO twice daily ☐ 30 mg PO once daily		
☐ Siliq™ (PSO)	☐ 210 mg/ 1.5 mL single-dose prefilled syringe	☐ 210 mg SQ day 0, 7 and 14, then every 2 weeks		
☐ Simponi® (PSA)	☐ 50 mg/ 0.5 mL SmartJect® autoinjector ☐ 50 mg/ 0.5 mL prefilled syringe ☐ 100 mg/ mL SmartJect® autoinjector ☐ 100 mg/ mL prefilled syringe	☐ 50 mg SQ every 4 weeks ☐ 200 mg SQ day 0; 100 mg day 7; then 100 mg every 4 weeks		
☐ Skyrizi™ (PSO)	☐ 75 mg/ 0.83 mL single-dose prefilled syringe	☐ 150 mg (two 75mg injections) SQ at weeks 0, 4 and every 12 weeks thereafter		
☐ Stelara® (PSO/PSA)	☐ 45 mg/ 0.5 mL prefilled syringe ☐ 90 mg/ 1 mL prefilled syringe	☐ Inject 45 mg SQ days 0, 28 and then every 12 weeks ☐ 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) week 0, then 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 / mL One-Press patient-controlled injector	☐ 100 mg SQ day 0 and 28, then every 8 weeks		
☐ OTHER				

Prescriber Information

Prescriber name:	Phone:	Office contact name:		
Prescriber address:	City:		State:	Zip:
NPI:	DEA:	Email / Fax:		
Signature:		Date:	☐ DO NOT SUBSTITUTE	