

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: <input type="checkbox"/> F <input type="checkbox"/> M	HT:
Address:		City:	State:	Zip Code:
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:		TB Test/Date:	<input type="checkbox"/> Patient is currently on therapy (Start date ___/___/___)	
Prior Therapies:				
Hepatic Encephalopathy / IBS-D / Traveler's Diarrhea				
Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Xifaxan®	<input type="checkbox"/> 200 mg <input type="checkbox"/> 550 mg	<input type="checkbox"/> Take one 200 mg tablet by mouth three times a day for 3 days <input type="checkbox"/> Take one 550 mg tablet by mouth two times a day <input type="checkbox"/> Take one 550 mg tablet by mouth three times a day for 14 days		
Crohn's Disease / Ulcerative Colitis				
Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> Starter Kit <input type="checkbox"/> 200 mg prefilled syringe	<input type="checkbox"/> Inject SQ 400 mg days 0, 14, 28 <input type="checkbox"/> Inject SQ 400 mg every 28 days		
<input type="checkbox"/> Humira® - Citrate Free	<input type="checkbox"/> Starter Kit - 80mg / 0.8mL <input type="checkbox"/> 40 mg/ 0.4 mL pens or prefilled	<input type="checkbox"/> 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 <input type="checkbox"/> Inject 40 mg SQ every other week		
<input type="checkbox"/> Entyvio®	<input type="checkbox"/> 300 mg/ 20 mL vial	<input type="checkbox"/> Infuse IV 300 mg weeks 0, 2, 6 <input type="checkbox"/> Infuse IV 300 mg every 8 weeks		
<input type="checkbox"/> Remicade®	<input type="checkbox"/> 100 mg/ 20 mL vial	<input type="checkbox"/> Infuse IV 5 mg/ kg weeks 0, 2, 6 <input type="checkbox"/> Infuse IV 5 mg/ kg every 8 weeks <input type="checkbox"/> Infuse IV		
<input type="checkbox"/> Rinvoq®	<input type="checkbox"/> 45 mg XR tablet <input type="checkbox"/> 15 mg XR tablet <input type="checkbox"/> 30 mg XR tablet	<input type="checkbox"/> Induction dose: 45 mg PO once daily for 8 weeks <input type="checkbox"/> 15 mg PO once daily <input type="checkbox"/> 30 mg PO once daily		
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 100 mg/ mL Smartject® Autojector <input type="checkbox"/> 100 mg/ mL prefilled syringe	<input type="checkbox"/> Inject SQ 200 mg week 0; 100 mg weeks 2, 6 <input type="checkbox"/> Inject SQ 100 mg every 4 weeks		
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 90 mg/ mL prefilled syringe	<input type="checkbox"/> Inject SQ 90 mg dose 8 weeks after the initial IV dose, then every 8 weeks Date of initial IV dose: _____		
<input type="checkbox"/> Xeljanz®	<input type="checkbox"/> 5 mg tablet <input type="checkbox"/> 10 mg tablet <input type="checkbox"/> 11 mg XR tablet <input type="checkbox"/> 22 mg XR tablet	<input type="checkbox"/> 5 mg PO twice daily <input type="checkbox"/> 10 mg PO twice daily for 8 weeks (maximum of 16 weeks) <input type="checkbox"/> XR 11 mg PO once daily <input type="checkbox"/> XR 22 mg PO once daily for 8 weeks (maximum of 16 weeks)		
<input type="checkbox"/> Zeposia®	<input type="checkbox"/> 7-Capsule Starter Kit <input type="checkbox"/> 0.92 mg capsule	<input type="checkbox"/> Dose titration: Take 0.23 mg capsule PO once daily on days 1 - 4. Then take 0.46 mg capsule PO once daily on days 5-7. <input type="checkbox"/> Take 0.92 mg capsule PO once daily		
<input type="checkbox"/> Other medication(s):				
Prescriber 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.