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:**	☐ **Patient is currently on therapy (Start date ____/_____/_______)**
Prior Therapies:		

Medication	Strength	Directions	Quantity	Refills
☐ Cimzia®	☐ Starter Kit	☐ Inject 400 mg SQ days 0, 14, 28		
	☐ 200 mg prefilled syringe	☐ Inject 400 mg SQ every 28 days		
☐ Dupixent®	☐ 300 mg/ 2 mL pre-filled syringe	☐ Inject 300 mg SQ once weekly		
	☐ 300 mg/ 2 mL pre-filled pen			
☐ 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	☐ 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		
☐ Rinvoq®	☐ 45 mg XR tablet	☐ *Induction dose:* 45 mg PO once daily for 8 weeks		
	☐ 15 mg XR tablet	☐ 15 mg PO once daily		
	☐ 30 mg XR tablet	☐ 30 mg PO once daily		
☐ Simponi®	☐ 100 mg/mL Smartject® Autojector	☐ Inject 200 mg SQ week 0; 100 mg weeks 2, 6		
	☐ 100 mg/mL prefilled syringe	☐ Inject 100 mg SQ every 4 weeks		
☐ Skyrizi®	☐ 360 mg/ 2.4 mL (150 mg/mL) single-dose prefilled cartridge	☐ Inject 360 mg SQ 12 weeks after the initial IV dose, then every 8 weeks **Dates of IV doses:** ______________________________		
☐ Stelara®	☐ 90 mg/ mL prefilled syringe	☐ Inject 90 mg SQ 8 weeks after the initial IV dose, then every 8 weeks **Date of initial IV dose**: ____________________________		
☐ Xeljanz®	☐ 5 mg tablet	☐ 5 mg PO twice daily		
	☐ 10 mg tablet	☐ 10 mg PO twice daily for 8 weeks *(maximum of 16 weeks)*		
	☐ 11 mg XR tablet	☐ XR 11 mg PO once daily		
	☐ 22 mg XR tablet	☐ XR 22 mg PO once daily for 8 weeks *(maximum of 16 weeks)*		
☐ Zeposia ®	☐ 7-Capsule Starter Kit	☐ Dose titration: 0.23 mg capsule PO once daily on days 1-4. Then 0.46 mg capsule PO once daily on days 5-7.		
	☐ 0.92 mg capsule	☐ 0.92 mg capsule PO once daily		
☐ 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:**	☐ **DO NOT SUBSTITUTE**	

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