

RHEUMATOID ARTHRITIS 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: <input type="checkbox"/> F <input type="checkbox"/> M	HT:	WT:		
Address:		City:	State:	Zip Code:	Phone:		
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:		Date of Diagnosis or Years with Disease:		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe			
Has patient been previously treated for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is patient currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		Will patient terminate current therapy upon start of new prescription? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Previous Therapy (dates):							
Is the patient taking methotrexate? <input type="checkbox"/> Yes <input type="checkbox"/> No		Latex allergy: <input type="checkbox"/> Yes <input type="checkbox"/> No		BMD/T-Site & Score & Date:		TB/PPD Test: <input type="checkbox"/> Yes <input type="checkbox"/> No Results:	
Medication	Dose / Strength	Directions		Quantity	Refills		
<input type="checkbox"/> Actemra	<input type="checkbox"/> 162 mg/0.9 ml PFS	<input type="checkbox"/> Inject 1 Syringe SQ once weekly <input type="checkbox"/> Inject 1 Syringe SQ every other week		4 week supply			
<input type="checkbox"/> Cimzia	<input type="checkbox"/> 200 mg Starter Kit (6x200 mg PFS) <input type="checkbox"/> 2 x 200 mg Prefilled Syringe	<input type="checkbox"/> Inject 400 mg SQ once. Repeat weeks 2 and 4 <input type="checkbox"/> Inject 200 mg SQ once every 2 weeks <input type="checkbox"/> Inject 400 mg SQ once every 4 weeks		4 week supply			
<input type="checkbox"/> Cosentyx	<input type="checkbox"/> 150 mg/ml single-use prefilled syringe <input type="checkbox"/> 150 mg/ml Sensoready pen	<input type="checkbox"/> Plaque psoriasis OR psoriatic arthritis, with coexistent moderate to severe plaque psoriasis: 300 mg by subcutaneous injection at weeks 0, 1, 2, 3, and 4 followed by 300 mg every 4 weeks. Psoriatic arthritis, administer with or without a loading dosage: <input type="checkbox"/> With a loading dosage is 150 mg at weeks 0, 1, 2, 3, and 4 and every 4 weeks thereafter. <input type="checkbox"/> Without a loading dosage is 150 mg every 4 weeks. <input type="checkbox"/> If a patient continues to have active psoriatic arthritis, consider a dosage of 300 mg. Ankylosing Spondylitis, administer with or without a loading dosage: <input type="checkbox"/> With a loading dosage is 150 mg at weeks 0, 1, 2, 3, and 4 and every 4 weeks thereafter <input type="checkbox"/> Without a loading dosage is 150 mg every 4 weeks.		4 week supply			
<input type="checkbox"/> Enbrel	<input type="checkbox"/> 25 mg Prefilled Syringe <input type="checkbox"/> 50 mg/mL SureClick Autoinjector <input type="checkbox"/> 50 mg/mL Prefilled Syringe <input type="checkbox"/> 50 mg/mL solution in Enbrel Mini™ single-dose prefilled cartridge for use with the AutoTouch™ reusable autoinjector only	<input type="checkbox"/> Inject 25 mg twice weekly, 72-96 hours apart <input type="checkbox"/> Inject 50 mg SQ once weekly <input type="checkbox"/> Other:		4 week supply			
<input type="checkbox"/> Forteo	<input type="checkbox"/> 600 mcg/2.4 ml Prefilled Syringe	<input type="checkbox"/> Inject 20 mcg SQ as directed once daily		4 week supply			
<input type="checkbox"/> Humira	<input type="checkbox"/> 40 mg/0.8 ml Pen <input type="checkbox"/> 40 mg/0.8 ml Prefilled Syringe	<input type="checkbox"/> Inject 40 mg SQ every other week <input type="checkbox"/> Inject 40 mg SQ once weekly		4 week supply			
<input type="checkbox"/> Kevzara	<input type="checkbox"/> 150 mg/1.14 ml Prefilled Syringe <input type="checkbox"/> 200 mg/1.14 ml Prefilled Syringe	<input type="checkbox"/> Inject 200 mg SQ once every 2 weeks		4 week supply			
<input type="checkbox"/> Orencia	<input type="checkbox"/> 125 mg/mL Prefilled Syringe (4) <input type="checkbox"/> 125 mg/mL ClickJect™ Autoinjector <input type="checkbox"/> 250 mg/15 mL vial (IV only)	<input type="checkbox"/> Inject 125 mg SQ once weekly <input type="checkbox"/> Infuse _____ mg IV every 4 weeks		_____ syringes _____ vials			
<input type="checkbox"/> Otezla	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 30 mg tablets	<input type="checkbox"/> Take as directed <input type="checkbox"/> Take 1 tablet twice daily		<input type="checkbox"/> 1 pack (2 week supply) <input type="checkbox"/> 60 tablets			
<input type="checkbox"/> Otrexup	Single-dose auto-injector <input type="checkbox"/> 7.5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 12.5 mg <input type="checkbox"/> 15 mg <input type="checkbox"/> 17.5 mg <input type="checkbox"/> 20 mg <input type="checkbox"/> 22.5 mg <input type="checkbox"/> 25 mg	<input type="checkbox"/> RA: 7.5 mg once weekly <input type="checkbox"/> pJIA: 10 mg/m2 once weekly <input type="checkbox"/> Psoriasis: 10 to 25 mg once weekly					
Prescriber Information							
Prescriber name:		Phone:	Office contact name:				
Prescriber address:		City:	State:	Zip:			
NPI:	DEA:	Email / Fax:					
Signature:			Date:	<input type="checkbox"/> DO NOT SUBSTITUTE			

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