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: ☐ 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:	Date of Diagnosis or Years with Disease:	□ Mild □ Moderate □ Severe

Has patient been previously treated for this condition? □ Yes □ No	Is patient currently on therapy? □ Yes □ No	Will patient terminate current therapy upon start of new prescription? □ Yes □ No

Previous Therapy (dates):

Is the patient taking methotrexate? □ Yes □ No	Latex allergy: □ Yes □ No	BMD/T-Site & Score & Date:	TB/PPD Test: □ Yes □ No Results:

Medication	Dose / Strength	Directions	Quantity	Refills
□ **Prolia**	□ 60 mg Prefilled Syringe	□ Inject 60 mg SQ once every 6 months		
□ **Rasuvo**	Single-dose manually-triggered auto-injector □ 7.5 mg □ 10 mg □ 12.5 mg □ 15 mg □ 17.5 mg □ 20 mg □ 22.5 mg □ 25 mg □ 27.5 mg □ 30 mg	□ RA: 7.5 mg once weekly □ pJIA: 10 mg/m2 once weekly □ Psoriasis: 10 to 25 mg once weekly		
□ **Remicade**	□ 100 mg/20 ml vial			
□ **Rituxan**	□ 10 mg/ml			
□ **Simponi**	□ 50 mg/0.5 ml Prefilled Syringe □ 50 mg/0.5 ml Autoinjector	□ Inject 50 mg SQ once a month	4 week supply	
□ **Stelara**	□ 45 mg Prefilled Syringe □ 90 mg Prefilled Syringe	□ Inject SQ weeks 0, 4 and every 12 weeks thereafter	4 week supply	
□ **Supartz**	□ 25 mg Prefilled Syringe	□ Inject 25 mg / 2.5 ml intra-articularly into knee once weekly for a total of 5 injections		
□ **Taltz**	□ 80 mg/mL prefilled syringe □ 80 mg/mL prefilled autoinjector	□ 160 mg SQ (two 80 mg injections) at Week 0, followed by 80 mg at Weeks 2, 4, 6, 8, 10, and 12, then 80 mg every 4 weeks □ 160 mg SQ (two 80 mg injections) at Week 0, followed by 80 mg every 4 weeks.		
□ **Xeljanz**	□ 5 mg tablets □ 11 mg ER tablets	□ Take 5 mg PO twice daily □ Take 11 mg PO once daily	4 week supply	

Prescriber Information

Prescriber name:	Phone:	Office contact name:

Prescriber address:	City:	State:	Zip:

NPI:	DEA:	Email / Fax:

Signature:	Date:	□ DO NOT SUBSTITUTE

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