

RHEUMATOID ARTHRITIS PRESCRIPTION FORM (P-Z)

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"/> Prolia	<input type="checkbox"/> 60 mg Prefilled Syringe	<input type="checkbox"/> Inject 60 mg SQ once every 6 months				
<input type="checkbox"/> Rasuvo	Single-dose manually-triggered 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"/> 27.5 mg <input type="checkbox"/> 30 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				
<input type="checkbox"/> Remicade	<input type="checkbox"/> 100 mg/20 ml vial					
<input type="checkbox"/> Rinvoq	<input type="checkbox"/> 15 mg extended-release tablets	<input type="checkbox"/> Take 15 mg PO once daily				
<input type="checkbox"/> Rituxan	<input type="checkbox"/> 10 mg/ml					
<input type="checkbox"/> Simponi	<input type="checkbox"/> 50 mg/0.5 ml Prefilled Syringe <input type="checkbox"/> 50 mg/0.5 ml Autoinjector	<input type="checkbox"/> Inject 50 mg SQ once a month		<input type="checkbox"/> 4 week supply		
<input type="checkbox"/> Stelara	<input type="checkbox"/> 45 mg Prefilled Syringe <input type="checkbox"/> 90 mg Prefilled Syringe	<input type="checkbox"/> Inject SQ weeks 0, 4 and every 12 weeks thereafter <input type="checkbox"/> Inject SQ every 12 weeks		<input type="checkbox"/> 4 week supply <input type="checkbox"/> 84 day supply		
<input type="checkbox"/> Supartz	<input type="checkbox"/> 25 mg Prefilled Syringe	<input type="checkbox"/> Inject 25 mg / 2.5 ml intra-articularly into knee once weekly for a total of 5 injections				
<input type="checkbox"/> Taltz	<input type="checkbox"/> 80 mg/mL prefilled syringe <input type="checkbox"/> 80 mg/mL prefilled autoinjector	<input type="checkbox"/> Inject 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 <input type="checkbox"/> Inject 160 mg SQ (two 80 mg injections) at Week 0, followed by 80 mg every 4 weeks <input type="checkbox"/> Inject 80 mg SQ every 4 weeks		<input type="checkbox"/> 28 day supply		
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5 mg tablets <input type="checkbox"/> 11 mg ER tablets	<input type="checkbox"/> Take 5 mg PO twice daily <input type="checkbox"/> Take 11 mg PO once daily		<input type="checkbox"/> 4 week supply		
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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