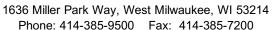
RHEUMATOID ARTHRITIS PRESCRIPTION FORM (P-Z)

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





		Patient In		ase provide a copy						
Patient Name:			DOB:		Gender: □ F □ M		HT:		WT:	
Address:			City:		State:	Zip Code:		Phone:		
						•				
Insurance:		Subscriber's na	me:		ID#:			Group #:		
Allergies: ☐ NKDA ☐ List allergies:		<u> </u>								
	Clinical Diagnos	sis: please fax	or email relevan		•		story to expedite pr			
Diagnosis / ICD-10:		Date of Diagnosis	or Years with Disea	se:		☐ Mild ☐ Mi	oderate Severe			
Has patient been previously treated	for this condition?	□ Yes □ No	Is patient current	tly on therapy?	Yes □ No	Will patient terr	minate current therap	y upon start of ne	ew prescription? Yes No	
Previous Therapy (dates):										
Is the patient taking methotrexate?	☐ Yes ☐ No	Latex allergy:]Yes □ No	BMD/T-Site & Sco	re & Date:		TB/PPD Test: Y	es □ No Re	sults:	
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			□ RA: 7.5 mg once	□ RA: 7.5 mg once weekly					
□ 7.5 mg □ 10 mg □ 12.5 mg			☐ 15 mg ☐ pJIA: 10 mg/m2 or		nce weekly					
	□ 17.5 mg □ 20 □ 27.5 mg □ 30		ı □ 25 mg	□ Psoriasis: 10 to 25 mg once weekly						
□ Remicade	□ 100 mg/20 ml vi									
□ Rinvoq	☐ 15 mg extended-release tablets			□ Take 15 mg PO o	once daily					
□ Rituxan	□ 10 mg/ml									
□ Simponi	☐ 50 mg/0.5 ml Prefilled Syringe			□ Inject 50 mg SQ once a month				☐ 4 week supply		
				, g						
	☐ 50 mg/0.5 ml Autoinjector									
□ Stelara	☐ 45 mg Prefilled	Syringe		□ Inject SQ weeks 0, 4 and every 12 weeks thereafter			☐ 4 week supply			
	☐ 90 mg Prefilled Syringe			□ Inject SQ every 12		! weeks		☐ 84 day supply		
□ Supartz	☐ 25 mg Prefilled Syringe			□ Inject 25 mg / 2.5 ml intra-articularly into knee once w			ekly for a total of 5			
	, ,			injections						
□ Taltz	☐ 80 mg/mL prefil	lled syringe		□ 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						
	☐ 80 mg/mL prefilled autoinjector ☐ Inject 160 mg SQ (two 80 mg injections) at Week 0, followed by 80 mg every									
	□ Inject 160 mg SQ (two 80 mg injections) at Week 0, followed by 80 mg ever 4 weeks				owed by 80 mg every					
				□ Inject 80 mg SQ e	every 4 weeks			☐ 28 day supply		
				T. 5 -5						
□ Xeljanz				□ Take 5 mg PO twice daily □ 4 week supply					1	
☐ 11 mg ER tablets				□ Take 11 mg PO once daily						
				Prescriber	Information					
Prescriber name:			Phone:				Office contact name	9:		
Prescriber address:			I	City:			1	State:	Zip:	
NPI:		DEA:			Email / Fax:			I		
		n.								
0: 1						In a			OTITUTE.	
Signature:						Date:		□ DO NOT SUB	SIIIUTE	

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