

RHEUMATOID ARTHRITIS PRESCRIPTION FORM (A-O)

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 single-dose prefilled syringe <input type="checkbox"/> 162mg/0.9 mL single-dose Prefilled ACTPen® (AKT-PEN) Autoinjector	<input type="checkbox"/> Inject 1 syringe SQ once weekly <input type="checkbox"/> Inject 1 syringe SQ every other week	<input type="checkbox"/> 4 week supply	
<input type="checkbox"/> Benlysta	<input type="checkbox"/> 200 mg/mL single-dose prefilled autoinjector <input type="checkbox"/> 200 mg/mL single-dose prefilled syringe	<input type="checkbox"/> Inject 200 mg SQ once weekly	<input type="checkbox"/> 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	<input type="checkbox"/> 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.	<input type="checkbox"/> 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:	<input type="checkbox"/> 4 week supply	
<input type="checkbox"/> Forteo	<input type="checkbox"/> 600 mcg/2.4 mL multi-dose pen	<input type="checkbox"/> Inject 20 mcg SQ as directed once daily	<input type="checkbox"/> 30 day supply	
<input type="checkbox"/> Humira - Citrate Free	<input type="checkbox"/> 40 mg/0.4 mL pens <input type="checkbox"/> 40 mg/0.4 mL prefilled syringes <input type="checkbox"/> 80 mg/0.8 mL pens	<input type="checkbox"/> Inject 40 mg SQ every other week <input type="checkbox"/> Inject 40 mg SQ once weekly <input type="checkbox"/> Inject 80 mg SQ every two weeks	<input type="checkbox"/> 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 150 mg SQ every other week <input type="checkbox"/> Inject 200 mg SQ every other week	<input type="checkbox"/> 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	<input type="checkbox"/> 4 week supply	
<input type="checkbox"/> Otezla	<input type="checkbox"/> Starter Pack (55 tablets) <input type="checkbox"/> 30 mg tablets	<input type="checkbox"/> Take as directed per package insert for proper titration <input type="checkbox"/> Take 1 tablet twice daily	<input type="checkbox"/> 28 day supply <input type="checkbox"/> 30 day supply	
<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		

Important Notice: This facsimile transmission is intended to be delivered only to the named recipient(s), and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named recipient, immediately notify the sender at the address and phone number set forth herein and obtain instructions as to properly dispose of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except authority of the sender to the named addressee.