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: ☐ F ☐ M	HT:	WT:

Address:	City:	State:	Zip Code:	Phone:

Insurance:	Subscriber's name:	ID#:	Group #:

Allergies: ☐ NKDA ☐ Latex allergy ☐ 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:	Disease Severity: ☐ Mild ☐ Moderate ☐ Severe	BMD/T-Site & Score & Date:	TB/PPD Test: ☐ Yes ☐ No Results:

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	Is there an immunomodulator prescribed? ☐ Yes ☐ No If YES, please indicate: ☐ Methotrexate ☐ Other:

Previous Therapy (include dates):	Current Therapy (include dates):

Medication	Dose / Strength	Directions	Quantity	Refills
☐ **Actemra**	☐ 162 mg/0.9 mL single-dose prefilled syringe	☐ Inject 1 syringe SQ once weekly	☐ 4 week supply	
	☐ 162mg/0.9 mL single-dose Prefilled ACTPen® (AKT-PEN) Autoinjector	☐ Inject 1 syringe SQ every other week		
☐ **Benlysta**	☐ 200 mg/mL single-dose prefilled autoinjector	☐ Inject 200 mg SQ once weekly	☐ 4 week supply	
	☐ 200 mg/mL single-dose prefilled syringe			
☐ **Cimzia**	☐ 200 mg Starter Kit (6x200 mg PFS)	☐ Inject 400 mg SQ once. Repeat weeks 2 and 4.	☐ 4 week supply	
	☐ 2 x 200 mg prefilled syringe	☐ Inject 200 mg SQ once every 2 weeks		
		☐ Inject 400 mg SQ once every 4 weeks		
☐ **Cosentyx**	☐ 150 mg/mL single-use prefilled syringe	☐ 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.	☐ 4 week supply	
	☐ 150 mg/mL Sensoready pen	Psoriatic arthritis, administer with or without a loading dosage: ☐ With a loading dosage is 150 mg at weeks 0, 1, 2, 3, and 4 and every 4 weeks thereafter. ☐ Without a loading dosage is 150 mg every 4 weeks. ☐ If a patient continues to have active psoriatic arthritis, consider a dosage of 300 mg.		
		Ankylosing Spondylitis, administer with or without a loading dosage: ☐ With a loading dosage is 150 mg at weeks 0, 1, 2, 3, and 4 and every 4 weeks thereafter ☐ Without a loading dosage is 150 mg every 4 weeks.		
☐ **Enbrel**	☐ 25 mg prefilled syringe	☐ Inject 25 mg twice weekly, 72-96 hours apart	☐ 4 week supply	
	☐ 50 mg/mL SureClick Autoinjector	☐ Inject 50 mg SQ once weekly		
	☐ 50 mg/mL prefilled syringe	☐ Other:		
	☐ 50 mg/mL solution in Enbrel Mini™ single-dose prefilled cartridge for use with the AutoTouch™ reusable autoinjector only			
☐ **Forteo**	☐ 600 mcg/2.4 mL multi-dose pen	☐ Inject 20 mcg SQ as directed once daily	☐ 30 day supply	
☐ **Humira - Citrate Free**	☐ 40 mg/0.4 mL pens	☐ Inject 40 mg SQ every other week	☐ 4 week supply	
	☐ 40 mg/0.4 mL prefilled syringes	☐ Inject 40 mg SQ once weekly		
	☐ 80 mg/0.8 mL pens	☐ Inject 80 mg SQ every two weeks		
☐ **Kevzara**	☐ 150 mg/1.14 mL prefilled syringe	☐ Inject 150 mg SQ every other week	☐ 4 week supply	
	☐ 200 mg/1.14 mL prefilled syringe	☐ Inject 200 mg SQ every other week		
☐ **Krystexxa**	☐ 8 mg/mL in single-dose vial	☐ Infuse 8 mg IV every two weeks	☐	
		☐ Other:	☐	
☐ **Orencia**	☐ 125 mg/mL prefilled syringe (4)	☐ Inject 125 mg SQ once weekly		
	☐ 125 mg/mL ClickJect™ Autoinjector		☐ 4 week supply	
	☐ 250 mg/15 mL vial (IV only)	☐ Infuse_____mg IV every 4 weeks		
☐ **Otezla**	☐ Starter Pack (55 tablets)	☐ Take as directed per package insert for proper titration	☐ 28 day supply	
	☐ 30 mg tablets	☐ Take 1 tablet twice daily	☐ 30 day supply	
☐ **Otrexup**	Single-dose auto-injector ☐ 7.5 mg ☐ 10 mg ☐ 12.5 mg ☐ 15 mg ☐ 17.5 mg ☐ 20 mg ☐ 22.5 mg ☐ 25 mg	☐ RA: 7.5 mg once weekly ☐ pJIA: 10 mg/m2 once weekly ☐ 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:	☐ DO NOT SUBSTITUTE