

Chicago Illinois  
4711 Golf Road  
Suite 900  
Skokie, IL 60076



REJUVEINATE

# ORDER FORM QUTENZA<sup>®</sup>(capsaicin)

Date: \_\_\_\_\_

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
Allergies:	Date of Referral:	

PHYSICIAN INFORMATION	
Physician Name*:	Practice Name:
Address:	Office Contact*:
Phone: _____ Fax: _____	Email (for updates): _____

REFERRAL STATUS	
<input type="checkbox"/> New Referral	<input type="checkbox"/> Referral Renewal
<input type="checkbox"/> Medication/Order Change	<input type="checkbox"/> Benefits Verification Only
<input type="checkbox"/> Discontinuation Order	

QUTENZA ORDER*:	
<i>(SELECT ONE OF THE FOLLOWING)</i>	
___ Dosing: 2 patches of 8% capsaicin (640 mcg per cm <sup>2</sup> ) every 3 months	<input type="checkbox"/> Other _____
___ Dosing: 3 patches of 8% capsaicin (640 mcg per cm <sup>2</sup> ) every 3 months	
___ Dosing: 4 patches of 8% capsaicin (640 mcg per cm <sup>2</sup> ) every 3 months	
Physician Signature _____	Date (Order is Valid for One Year) _____
	<i>Infusion will be administered per MPP policy and protocols</i>

**Apply For:**

- 30 min.
- 60 min.
- Other \_\_\_\_\_

**Total Doses:**

- 1 yr
- Other \_\_\_\_\_

REQUIRED DIAGNOSIS:
___ Neuropathic pain associated with postherpetic neuralgia (PHN)
___ Neuropathic pain associated with diabetic peripheral neuropathy (DPN)
___ Other _____
Last Infusion/Injection Date: _____

REQUIRED DOCUMENTATION CHECKLIST:
___ Patient Demographics
___ Insurance Card/Information
___ Clinical/Progress Notes supporting DX
___ Current Medication List and H&P
___ Capsaicin 8% Topical System Procedure Notes
___ Other

NOTES/ADDITIONAL COMMENTS:

## ORDERING PROVIDER

Signature X \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_