

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



ORDER FORM RADICAVA[®]

Date: _____

PATIENT INFORMATION	
Name:	DOB: SEX: M F
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	

RADICAVA*:

(SELECT ONE OF THE FOLLOWING)

- ___ Dosing: 2 patches of 8% capsaicin (640 mcg per cm²) every 3 months
- ___ Dosing: 3 patches of 8% capsaicin (640 mcg per cm²) every 3 months
- ___ Dosing: 4 patches of 8% capsaicin (640 mcg per cm²) every 3 months

Physician Signature _____ Date (Order is Valid for One Year) _____

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

STANDING LAB ORDERS (to be drawn at clinic): ___ CMP ___ CBC *Frequency _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____