

Los Angeles, CA  
2080 Century Park East  
Suite 710  
Los Angeles, CA 90067



# ORDER FORM RADICAVA<sup>®</sup>

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 cm<sup>2</sup>) every 3 months
- \_\_\_ 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) \_\_\_\_\_

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 \_\_\_\_\_