

TN  
100 Covey Drive  
Suite 307  
Franklin, TN 37067



# ORDER FORM SUBLOCADE®

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

## SUBLOCADE\*:

(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 \_\_\_\_\_