

Chicago Illinois
4711 Golf Road
Suite 900
Skokie, IL 60076

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 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 _____