

Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830



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 _____