

Vermont
28 Park Ave
Suite #1A
Williston, VT 05495



ORDER FORM QUTENZA[®](capsaicin) 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	
☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ Discontinuation Order	

QUTENZA ORDER*:	
<i>(SELECT ONE OF THE FOLLOWING)</i>	
____ Dosing: 2 patches of 8% capsaicin (640 mcg per cm ²) every 3 months ☐ Other ____	Apply For: ☐ 30 min. ☐ 60 min. ☐ Other ____
____ Dosing: 3 patches of 8% capsaicin (640 mcg per cm ²) every 3 months	
____ Dosing: 4 patches of 8% capsaicin (640 mcg per cm ²) every 3 months	
Physician Signature _____	Total Doses: ☐ 1 yr ☐ Other ____
Date (Order is Valid for One Year) _____ <i>Infusion will be administered per MPP policy and protocols</i>	

REQUIRED DIAGNOSIS:	REQUIRED DOCUMENTATION CHECKLIST:
____ Neuropathic pain associated with postherpetic neuralgia (PHN)	____ Patient Demographics
____ Neuropathic pain associated with diabetic peripheral neuropathy (DPN)	____ Insurance Card/Information
____ Other _____	____ Clinical/Progress Notes supporting DX
	____ Current Medication List and H&P
	____ Capsaicin 8% Topical System Procedure Notes
	____ Other
Last Infusion/Injection Date: _____	

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____