

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



ORDER FORM SUBLOCADE®

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	

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 _____