

Westerville
575 Copeland Mill Road
Suite# 2F
Westerville, Ohio 43081



Lancaster
2405 Columbus Street
Suite# 210
Lancaster, Ohio 43130

ORDER FORM QUTENZA[®](capsaicin) 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	

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

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 _____