

Lexington  
1792 Alysheba Way  
Suite 205  
Lexington, KY 40509

Bowling Green  
727 U.S. 31 W Bypass  
Suite 102  
Bowling Green, KY 42101



# ORDER FORM RADICAVA®

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	
<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	

## RADICAVA\*:

(SELECT ONE OF THE FOLLOWING)

- \_\_\_ Dosing: 2 patches of 8% capsaicin (640 mcg per cm<sup>2</sup>) every 3 months
- \_\_\_ Dosing: 3 patches of 8% capsaicin (640 mcg per cm<sup>2</sup>) every 3 months
- \_\_\_ Dosing: 4 patches of 8% capsaicin (640 mcg per cm<sup>2</sup>) every 3 months

Physician Signature \_\_\_\_\_ Date (Order is Valid for One Year) \_\_\_\_\_

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

STANDING LAB ORDERS (to be drawn at clinic): \_\_\_ CMP \_\_\_ CBC \*Frequency \_\_\_\_\_

NOTES/ADDITIONAL COMMENTS:

## ORDERING PROVIDER

Signature X \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_