Borough Park
1428 36th Street
Suite 107
Brooklyn, NY 11218

Forest Hills
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

Sheepshead Bay
2546 East 17th Street
Fl, 1
Brooklyn, NY 11235

Long Island City
36-36 33rd
Suite 311
Long Island City, NY 11106

Bronx
226 West 238th Street
Bronx, NY 10463

Massapequa
97 Grand Avenue
Massapequa, NY 11758

NYC

E 56th & Park Midtown
120 East 56 Street
Suite 300
New York, NY 10022

E 70th St Upper East Side
225 E 70th Street
Suite 1E
New York, NY 10021

FIDI
30 Broad Street
Suite 401
New York, NY 10004

Central Park West
115 Central Park West
Suite 15
New York, NY 10023

Gramercy
7 Gramercy Park West
Lower Level
New York, NY, 10003

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

Tarrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Port Jefferson
12 Medical Drive
Suite B
Port Jefferson Station, NY 11776

Staten Island
27 New Dorp Lane
Staten Island, NY 10306

Southampton
625 Hampton Road
Southampton, NY 11968

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

Holbrook
233 Union Avenue
Suite 207
Holbrook, NY 11741

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

Rockville Centre
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

New Hyde Park
1991 Marcus Ave
Suite 110
Lake Success, NY, 11042

Woodbury
7600 Jericho Tpke,
Lower Level, Suite C500
Woodbury NY 11797

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

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

RADICAVA*:

*(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 postehrpetic 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 _____