

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



Lancaster  
2405 Columbus Street  
Suite# 210  
Lancaster, Ohio 43130

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

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

| NOTES/ADDITIONAL COMMENTS: |
|----------------------------|
|                            |

## ORDERING PROVIDER

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

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