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

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

Mission Medical

ORDER FORM
QUTENZA®(capsaicin)

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

QUTENZA ORDER*:

*(SELECT **ONE** OF THE FOLLOWING)*

____ Dosing: 2 patches of 8% capsaicin (640 mcg per cm2) every 3 months ☐Other _____

____ 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

Apply For:
☐ 30 min.
☐ 60 min.
☐ Other_____

Total Doses:
☐ 1 yr
☐ Other_____

Physician Signature _____ * **Date (Order is Valid for One Year)** _____ *

Infusion will be administered per MPP policy and protocols

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

____ Other

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____