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

ThrIVewell™ INFUSION

Mission Medical

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

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 _____