

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



ORDER FORM QUTENZA[®](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>	Apply For:
___ Dosing: 2 patches of 8% capsaicin (640 mcg per cm ²) every 3 months <input type="checkbox"/> Other ___	<input type="checkbox"/> 30 min.
___ Dosing: 3 patches of 8% capsaicin (640 mcg per cm ²) every 3 months	<input type="checkbox"/> 60 min.
___ Dosing: 4 patches of 8% capsaicin (640 mcg per cm ²) every 3 months	<input type="checkbox"/> Other _____
Physician Signature _____	Total Doses:
Date (Order is Valid for One Year) _____	<input type="checkbox"/> 1 yr
<i>Infusion will be administered per MPP policy and protocols</i>	<input type="checkbox"/> Other _____

REQUIRED DIAGNOSIS:
___ Neuropathic pain associated with postherpetic 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 _____