*TN*
100 Covey Drive
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# 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 _____________