

# QUTENZA (CAPSAICIN 8% TOPICAL) ORDER FORM

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Mobile Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_ kg  
 Allergies: \_\_\_\_\_  
 New Start Therapy |  Continuation of Therapy & Date of last dose (if applicable): \_\_\_\_\_

## DIAGNOSIS (Provider must specify)

Type I diabetes mellitus with diabetic neuropathy, ICD 10: E10.4 \_\_\_\_\_  
 Type II diabetes mellitus with diabetic neuropathy, ICD 10: E11.4 \_\_\_\_\_  
 Postherpetic neuropathy, ICD 10: B02. \_\_\_\_\_  
 Other: \_\_\_\_\_

## PROVIDER INFORMATION

Provider Name (print name): \_\_\_\_\_ Provider NPI: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

**Prerequisites to treatment** – ensure the following information is complete and attached with referral:

- Demographics     Labs and tests supporting diagnosis     Office/progress notes

## PRE-MEDICATION (Not typically indicated)

Acetaminophen (Tylenol) 500 mg PO     Famotidine 20 mg IV     Methylprednisolone (Solu-Medrol) 125 mg IVP  
 Benadryl 25mg PO     Cetirizine (Zyrtec) 10 mg PO  
 Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

## MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Qutenza	<input type="checkbox"/> Single 30 minute application of up to 4 topical systems <input type="checkbox"/> Single 60 minute application of up to 4 topical systems	# of patches: _____ Site(s): _____ (indicate location(s) on body)	<input type="checkbox"/> Every 3 months <input type="checkbox"/> Other: _____

## LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: \_\_\_\_\_

**FAX NUMBERS:**

CT: 203.433.0621  
 FL: 904.877.9270

MA: 413.296.8482  
 MD: 240.224.8607  
 ME: 207.407.7272

NC: 919.984.8698  
 NH: 603.217.5371  
 NJ: 201.581.4521

NY: 631.250.6020  
 OH: 937.871.4594  
 PA: 610.273.5998

SC: 864.973.6279  
 VA: 703.202.0499