

# QUTENZA (CAPSAICIN 8% TOPICAL) ORDER FORM

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mobile Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_

Allergies: \_\_\_\_\_

## 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: B02.2 \_\_\_\_\_
- 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	<input type="checkbox"/> Topical to be applied to _____ (indicate location on body, i.e Right Foot, Left Foot, etc)	<input type="checkbox"/> Every 3 months <input type="checkbox"/> Other _____

New Start Therapy     Continuation of Therapy    Date of last dose (if applicable): \_\_\_\_\_

## LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS:  NH: 603.217.5371     ME: 207.407.7272

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