Local Infusion

MYLOCALINFUSION.COM

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

❑ Benadryl 25mg PO

❑ Famotidine 20 mg IV

❑ Cetirizine (Zyrtec) 10 mg PO

❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Other: ______________ Dose: __________ Route: __________

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Qutenza	❑ Single 30 minute application of up to 4 topical systems ❑ Single 60 minute application of up to 4 topical systems	❑ Topical to be applied to __________ (indicate location on body, i.e Right Foot, Left Foot, etc)	❑ Every 3 months ❑ Other __________

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): __________

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❑ CT: 203.433.0621 ❑ ME: 207.407.7272 ❑ NH: 603.217.5371 ❑ NJ: 201.581.4521

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