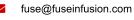


9	175MemorialHighway.Suite1-1
Ť	NewRochelle,NY
	1080

•	914-460-489

_____ ok the switch to biosimilar if insurance formulary prefers



914-460-4571

OKDEK FORM OLITENIZA	
QUTENZA (capsaicin)	Dafe:

	PATIENT INFORMATION	V		
Name:	DOB:	•	SEX: M F	
Allergies:	Date of Referral:			
	PHYSICIAN INFORMATION)NI		
Physician Name*:	Practice Name:)IN		
Address:	Office Contact*:			
Phone: Fax:	Email (for updates):			
	REFERRAL STATUS			
□New Referral □Referral Renewal □N		erification Only	☐ Discontinuation Order	
QUTENZA ORDER*: (SELECT ONE OF THE FOLLOWING)				
Dosing: 2 patches of 8% capsaicin (64	,			
Dosing: 3 patches of 8% capsaicin (64	,			
Dosing: 4 patches of 8% capsaicin (64	0 mcg per cm2) every 3 months			
Physician Signature *	Date (Order is Valid for One Year) Infusion will be administered per MPP policy *	y and protocols		
REQUIRED DIAGNOSIS:	REQUIRED DOC	UMENTATION	N CHECKLIST:	
Neuropathic pain associated with postehr	etic neuralgia Patient Demo	ographics		
(PHN)	Insurance Car	Insurance Card/Information		
Neuropathic pain associated with diabetic	peripheral Clinical/Progr	Clinical/Progress Notes supporting DX		
neuropathy (DPN)	Current Medic	Current Medication List and H&P		
Other	Capsaicin 8% T	Capsaicin 8% Topical System Procedure Notes		
Last Infusion/Injection Date:				
NOTES ADDITIONAL COMMENTS:				
NOTES/ADDITIONAL COMMENTS:				
ODDEDING DROVIDED				
ORDERING PROVIDER				

Provider _____ Phone ____ Fax _____