Capsaicin 8% topical system (Qutenza®) Referral Form

Please complete the following and fax with clinical documentation to: 720.279.7461

Referral Process

Averitas Key Account Manager's Name ____________________

1. PATIENT INFORMATION (*indicates a required field)	2. PHYSICIAN INFORMATION (*indicates a required field)
Name*: ____________________	Physician's name*: ____________________
Address*: ____________________	License #: __________ NPI #*: __________
City*: __________ State*: _____ Zip*: _____	DEA #: __________ Email*: __________
Home Phone: __________ Mobile Phone*: __________	Address*: ____________________
Email*: ____________________ Primary language*: ____________________	City*: ____________________ State*: _____ Zip*: __________ Practice Name: __________
DOB*: __________ Social Security #*: __________	Office Contact: ____________________
Gender*: ☐ M ☐ F Height: _____ Weight*: _____	Phone*: __________ Fax*: __________ Specialty*: __________

Allergies*: ____________________ NKA*: ☐

Alternate contact name: __________ Alternate contact phone: __________

☐ Yes ☐ No* Consent to leave voice message at the patient and/or alternate contact phone

3. DIAGNOSIS *(*indicates a required field) Year of diagnosis: __________

- ☐ B02.23 Postherpetic Polyneuropathy
- ☐ B02.29 Other postherpetic nervous system involvement
- ☐ E08.40 Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified
- ☐ E08.42 Diabetes mellitus due to underlying condition with diabetic polyneuropathy
- ☐ E10.40 Type 1 diabetes mellitus with diabetic neuropathy, unspecified
- ☐ E10.42 Type 1 diabetes mellitus with diabetic polyneuropathy
- ☐ E11.40 Type 2 diabetes mellitus with diabetic neuropathy, unspecified
- ☐ E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy
- ☐ E13.40 Other specified diabetes mellitus with diabetic neuropathy, unspecified
- ☐ E13.41 Other specified diabetes mellitus with diabetic mononeuropathy
- ☐ E13.42 Other specified diabetes mellitus with diabetic polyneuropathy
- ☐ Other diagnoses: ____________________

4. INSURANCE INFORMATION: Name of Insurance Provider ____________________

Please submit copies of the front and back of primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION Anticipated Start Date: ____________________

Prescription*: QUTENZA 8% Patch Capsaicin (640 mcg/cm^2) for topical use only. Must be applied or removed by a healthcare professional **(PLEASE FILL IN QTY TO DISPENSE)**

☐ Postherpetic neuropathy: Apply up to 4 topical systems up to 60 minutes

Dispense: ______QTY (topical systems-not to exceed 4)

☐ Diabetic peripheral neuropathy: Apply up to 4 topical systems up to 30 minutes on the feet

Dispense: ______QTY (topical systems-not to exceed 4)

Premedication orders: ____________________

Additional orders: _____

REFILLS: __________

6.

PHYSICIAN'S SIGNATURE (required): ____________________ **Date:** __________

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Prescription is valid for one year unless otherwise indicated. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.