

Capsaicin 8% topical system (Qutenza®) Referral Form

Please complete the following and fax with clinical documentation to: 720.870.2414

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*: _____	City*: _____ State*: _____
Primary language*: _____	Zip*: _____ Practice Name: _____
DOB*: _____ Social Security #: _____	Office Contact: _____
Gender*: <input type="checkbox"/> M <input type="checkbox"/> F Height: _____ Weight*: _____	Phone*: _____ Fax*: _____
Specialty*: _____	
Allergies*: _____ NKA*: <input type="checkbox"/>	
Alternate contact name: _____ Alternate contact phone: _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No* Consent to leave voice message at the patient and/or alternate contact phone	
3. DIAGNOSIS (*indicates a required field) Year of diagnosis: _____	
<input type="checkbox"/> B02.23 Postherpetic Polyneuropathy <input type="checkbox"/> B02.29 Other postherpetic nervous system involvement <input type="checkbox"/> E08.40 Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified <input type="checkbox"/> E08.42 Diabetes mellitus due to underlying condition with diabetic polyneuropathy <input type="checkbox"/> E10.40 Type 1 diabetes mellitus with diabetic neuropathy, unspecified <input type="checkbox"/> E10.42 Type 1 diabetes mellitus with diabetic polyneuropathy <input type="checkbox"/> E11.40 Type 2 diabetes mellitus with diabetic neuropathy, unspecified <input type="checkbox"/> E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy <input type="checkbox"/> E13.40 Other specified diabetes mellitus with diabetic neuropathy, unspecified <input type="checkbox"/> E13.41 Other specified diabetes mellitus with diabetic mononeuropathy <input type="checkbox"/> E13.42 Other specified diabetes mellitus with diabetic polyneuropathy <input type="checkbox"/> 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) <input type="checkbox"/> Postherpetic neuropathy: Apply up to 4 topical systems up to 60 minutes Dispense: _____ QTY (topical systems-not to exceed 4) <input type="checkbox"/> 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: _____	