REVITALIZE
INFUSION CENTER

Qutenza®

Order Form

Patient Information:

_____	_____	_____
Patient Name	**DOB**	**Phone Number**

Medical Information:

Primary Diagnosis:

- ☐ Diabetic peripheral neuropathy — ICD-10 Code: E11.40
- ☐ Postherpetic polyneuropathy — ICD-10 Code: B02.23
- ☐ Other_____ — ICD-10 Code: _____

Allergies: _____ (or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Medication List
  - Include previously tried and failed therapies

Height: _____

Weight: _____

Qutenza (capsaicin) 8% topical system Orders:

- ☐ 1 Kit (carton includes 1 topical system and cleansing gel)
- ☐ 2 Kits (carton includes 2 topical systems and cleansing gel)
- ☐ 4 Kits (carton includes 4 topical systems and cleansing gel)

Directions: Place _____ (# of patch(es)) on each foot every _____ weeks (no more frequently than every 12 weeks) for _____ administrations

Pre-Medication Orders: _____

*No pre-medications are recommended based on the manufacturer's PI

Lab Orders: _____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____	_____
Prescriber's Signature	**Date**
_____	_____
Prescriber's Printed Name	**Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

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