Phone: (847) 324-6800 Fax: (224) 251-7141 Email: intake@infusacare.com

InfusaCare
MedFuse

# Qutenza (Capsaicin Kit) Topical Application Order

Patient Name: DOB: □ Male □ Female

Diagnosis (please provide ICD10 code):

□ Other:

□ NKDA □ Allergies:

□ New Therapy Order □ Continuation of Therapy Date of last dose:

Ordering Provider Name:

Provider NPI: Phone: Fax:

Practice Address: City: State: Zip Code:

**Pre-Medication**

□ Acetaminophen _____mg by □ PO
□ Ceterizine _____mg by □ PO
□ Diphenhydramine _____mg by □ PO/ □ IVP
□ Solu-Medrol _____mg by □ PO/ □ IVP
□ Solu-Cortef _____mg by □ PO/ □ IVP
□ Other:

**Required Documentation:**

□ Patient Demographics
□ Patient Insurance (med and pharm card copies, front and back)
□ Progress Notes/Labs supporting diagnosis
□ Capsaicin 8% topical system procedure notes
□ Other:

**Patient height and weight:**

Patient Height (cm): Patient Weight (kg):

**Qutenza Medication Order**

- Dosing
  - □ 2 patches of 8% capsaicin (640 mcg per cm2) every 3 months
  - □ 3 patches of 8% capsaicin (640 mcg per cm2) every 3 months
  - □ 4 patches of 8% capsaicin (640 mcg per cm2) every 3 months
- Apply for:
  - □ 30 minutes
  - □ 60 minutes
  - □ Other: _____
- Total Doses
  - □ 1 year
  - □ Other: _____

**Additional Instructions/Notes:**

**Ordering Provider:**

Signature: _____ Date: _____

Provider: _____ Phone: _____ Fax: _____

Best Contact Person in Office: _____ Phone: _____