

Sublocade Medication 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
- Cetirizine _____ 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
- History of tried and failed therapies, including duration
- CBC/CMP
- Current Medication List
- 8% Capsaicin Topical System Procedure Notes
- Other: _____

Patient Height and Weight:

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

Sublocade Medication Order:

▪ Dosing (Please choose one):

- 2 patches of 8% capsaicin
- 3 patches of 8% capsaicin
- 4 patches of 8% capsaicin
- Other: _____

▪ Frequency (Please choose one):

- Every 3 months
- Other: _____

Additional Instructions/Notes:

Ordering Provider:

Signature: _____

Date: _____

Provider: _____

Phone: _____ Fax: _____

Best Contact Person in Office: _____

Phone: _____

Locations:

- Skokie, IL: 4711 Golf Rd, Ste 900. P: 847-324-6800. F: 224-251-7141
- Libertyville, IL: 1900 Hollister Dr, Ste 210. P: 847-324-6800. F: 224-251-7141
- Houston, TX: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400