

☐ **Borough Park**
1428 36th Street
Suite 107
Brooklyn, NY 11218

☐ **Crown Heights**
555 Lefferts Avenue
Brooklyn, NY 11225

☐ **Manhattan**
57W 57Street
Suite 601
New York, NY 10019

☐ **Manhasset**
333 East Shore Road
Suite 201
Manhasset, NY 11030

☐ **Rockville Centre**
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

☐ **Elmsford/ Terrytown**
555 Taxter Road
3rd Floor
Elmsford, NY 10523



☐ **Manhattan**
225 E 70th Street
Suite 1E
New York, NY 10021

☐ **Queens**
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ **Manhattan**
225 East 70th Street
New York, NY 10021

☐ **Holbrook/ Ronkonkoma**
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ **Scarsdale**
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

☐ **5 Towns**
141 Washington Avenue
Cedarhurst, NY 11559

☐ **Long Beach**
917 Beech Street
Long Beach, NY 11561

☐ **Riverhead**
1228 E Main Street
Suite A
Riverhead, NY 11901

ORDER FORM QUTENZA[®](capsaicin)

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
Allergies:	Date of Referral:	

PHYSICIAN INFORMATION

Physician Name*:	Practice Name:
Address:	Office Contact*:
Phone: Fax:	Email (for updates):

REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ Discontinuation Order

QUTENZA ORDER*:

(SELECT ONE OF THE FOLLOWING)

___ Dosing: 2 patches of 8% capsaicin (640 mcg per cm²) every 3 months ☐ Other ___
___ Dosing: 3 patches of 8% capsaicin (640 mcg per cm²) every 3 months
___ Dosing: 4 patches of 8% capsaicin (640 mcg per cm²) every 3 months

Apply For:

☐ 30 min.
☐ 60 min.
☐ Other _____

Total Doses:

☐ 1 yr
☐ Other _____

Physician Signature _____

Date (Order is Valid for One Year) _____
Infusion will be administered per MPP policy and protocols

REQUIRED DIAGNOSIS:

___ Neuropathic pain associated with postherpetic neuralgia (PHN)
___ Neuropathic pain associated with diabetic peripheral neuropathy (DPN)
___ Other _____

Last Infusion/Injection Date: _____

REQUIRED DOCUMENTATION CHECKLIST:

___ Patient Demographics
___ Insurance Card/Information
___ Clinical/Progress Notes supporting DX
___ Current Medication List and H&P
___ Capsaicin 8% Topical System Procedure Notes
___ Other _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X Date _____

Provider _____ Phone _____ Fax _____