

Chicago Illinois
4711 Golf Road
Suite 900
Skokie, IL 60076



ORDER FORM RADICAVA®

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	

RADICAVA*:

(SELECT ONE OF THE FOLLOWING)

- ____ Dosing: 2 patches of 8% capsaicin (640 mcg per cm²) every 3 months
- ____ 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

Physician Signature _____ Date (Order is Valid for One Year) _____

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

STANDING LAB ORDERS (to be drawn at clinic): ____ CMP ____ CBC *Frequency _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____