*TN*
100 Covey Drive
Suite 307
Franklin, TN 37067

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

REJUVEINATE

# ORDER FORM SUBLOCADE®

**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

## SUBLOCADE*:

*(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 postehrpetic 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 _____