QUTENZA (Capsaicin 8% topical system)

Provider Order Form *02/06/2025*

710 Nashville Pike, Suite 103
Gallatin. TN. 37066
P: (615) 471-8673 : F: (615) 471-8674
www.ivcareinfusion.com
E: info@ivcareinfusion.com

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

☐ NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

DIAGNOSIS

☐ E08.40 Diabetes mellitus due to underlying condition w/ diabetic neuropathy, unspecified
☐ E10.40 Type 1 diabetes mellitus with diabetic neuropathy, unspecified
☐ E11.40 Type 2 diabetes mellitus with diabetic neuropathy, unspecified
☐ B02.23 Postherpetic polyneuropathy
☐ Other Dx: _____

☐ E08.42 Diabetes mellitus due to underlying condition w/ diabetic polyneuropathy
☐ E10.42 Type 1 diabetes mellitus with diabetic polyneuropathy
☐ E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy
☐ B02.29 Other postherpetic nervous system involvement

NURSING

☑ Provide nursing care per IVCare Infusion's Procedures, including reaction management and post-procedure observation

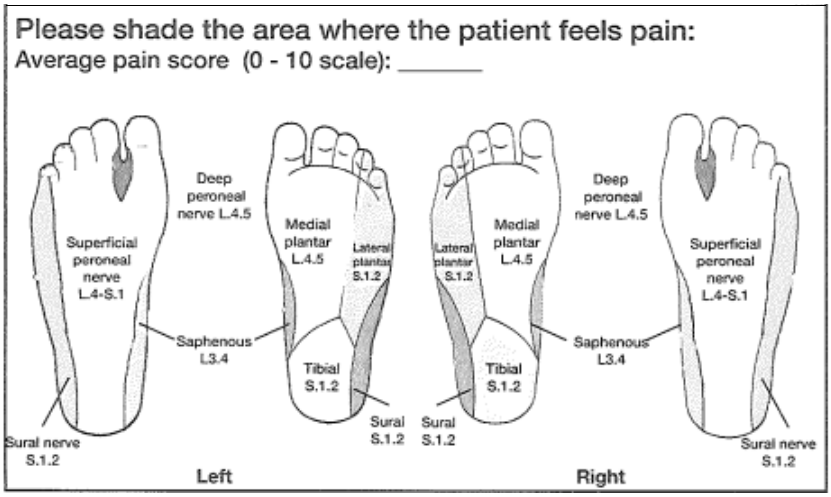
PREMEDICATIONS

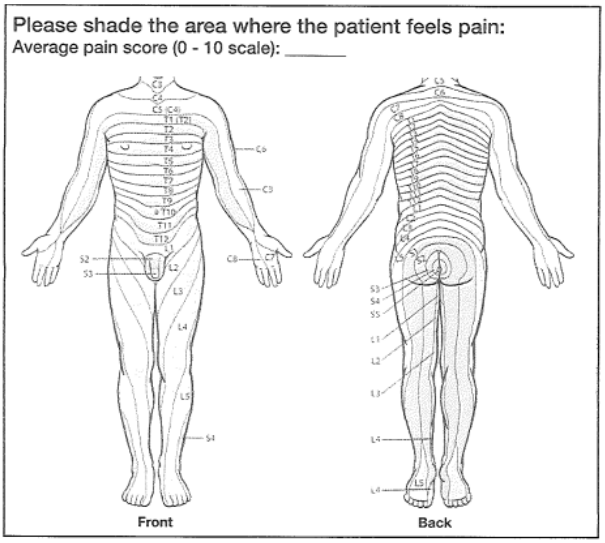
☐ acetaminophen (Tylenol) ☐ 500mg ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO ☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____

QUTENZA THERAPY ADMINISTRATION

☐ 2 patches of 8% capsaicin (640 mcg per cm^2) every 3 months
☐ 3 patches of 8% capsaicin (640 mcg per cm^2) every 3 months
☐ 4 patches of 8% capsaicin (640 mcg per $cm^{2)}$ every 3 months

SITE/LOCATION OF APPLICATION





Special Instructions:

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print) **Provider Signature** **Date**

Email: info@ivcareinfusion.com or fax this Form, Insurance card (both sides), Demographics, Recent H&P, Labs & supporting Clinicals to : (615) 471-8674