TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

QUTENZA®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____
NPI #: _____ Tax ID: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____
Plan #: _____
Group #: _____
RX Card (PBM): _____
BIN: _____ PCN: _____

Secondary Insurance (If Applicable): _____
Plan #: _____
Group #: _____
RX Card (PBM): _____
BIN: _____ PCN: _____

CLINICAL INFORMATION

☐ **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**
☐ **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**
☐ **Other:** _____

ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose/Frequency	Quantity	Refills
☐ Qutenza (capsaicin 8% patch)	☐ 2 patches of 8% capsaicin (640 mcg per cm2) every 3 months ☐ 3 patches of 8% capsaicin (640 mcg per cm2) every 3 months ☐ 4 patches of 8% capsaicin (640 mcg per cm2) every 3 months ☐ Other:_____	☐ 2 patches ☐ 3 patches ☐ 4 patches ☐ _____	

Pre-Medication	Dose/Strength	Directions
☐ Acetaminophen	☐ 500mg	☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed
☐ Diphenhydramine	☐ 25mg IV/PO ☐ 50mg IV/PO	☐ Take 1 tablet PO prior to infusion or as directed OR ☐ Inject contents of 1 vial IV prior to infusion or as directed
☐ Methylprednisolone	☐ 40mg ☐ 100mg ☐ 125mg	☐ Inject contents of 1 vial IV prior to infusion or as directed ☐ Other: Inject 100mg IV 30 minutes prior to infusion
☐ _____	_____	_____

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X_____ Date: _____
Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.