



Fax Referrals To: (855) 891-2191
 Email Referrals To: referrals@vivoinfusion.com
 Have a Question? (855) 478-1528

QUTENZA® (capsaicin) ORDER FORM
 (* - Required Fields)

STAT REQUEST
 (*REASON MUST BE PROVIDED BELOW)

New Referral	Referral Renewal	Medication/Treatment Change
Benefits Verification Only		Discontinuation Order
PATIENT INFORMATION		
NAME*:		DOB*:
ADDRESS:		SEX: <input type="checkbox"/> M <input type="checkbox"/> F
WEIGHT: LBS	KG	HEIGHT:
ALLERGIES:		EMAIL:
PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL (FOR UPDATES):
<p>QUTENZA Order*: (SELECT ONE OF THE FOLLOWING)</p> <p>2 patches of 8% capsaicin (640 mcg per cm2) every 3 months</p> <p>3 patches of 8% capsaicin (640 mcg per cm2) every 3 months</p> <p>4 patches of 8% capsaicin (640 mcg per cm2) every 3 months</p>		
<p>Physician Signature* _____ Date*(Referral Valid for One Year) _____</p> <p>*NPI # _____ <i>Infusion will be administered per VIVO policy and protocols</i></p>		
ICD-10 Description:	REQUIRED DOCUMENTATION CHECKLIST:	
<p>*STAT REASON: (STAT requests will be assessed per VIVO policy and protocols)</p> <p>Last Infusion/Injection Date: _____</p>	<p>Patient Demographics</p> <p>Insurance Card/Information</p> <p>Progress Notes supporting DX</p> <p>Current Medication List and H&P</p> <p>Capsaicin 8% Topical System</p> <p>Procedure Notes</p>	
<p>STANDING LAB REQUEST (to be drawn by clinic): CMP CBC *Frequency _____</p>		
<p>Additional comments/notes:</p>		

Locations:

-----Colorado-----

Lakewood

-----Florida-----

Jacksonville
 Kissimmee
 Port St. Lucie
 Suncoast
 Winter Park

-----Ohio-----

Beachwood
 Middleburg Hts.
 Painesville
 Youngstown
 Westlake
 Fairlawn

-----Oklahoma-----

Tulsa

-----Texas-----

Arlington
 Cedar Hill
 Dallas
 Denton
 Ft. Worth
 Irving
 Rockwall
 Southlake
 Flower Mound
 Plano
 Tyler