



# MEDICA HEALTHCARE SERVICES

## INJECTIONS AND INFUSION SPECIALTY

CHRONIC & RARE DISEASES



### QUTENZA Medication Order Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: \_\_\_\_\_ Weight (lb/kg) \_\_\_\_\_ Height: \_\_\_\_\_

☐ NKDA Allergies: \_\_\_\_\_

☐ New Referral ☐ Updated Referral ☐ Referral Renewal

**DIAGNOSIS** ICD-10 Code (Required): \_\_\_\_\_ ICD-10 Description: \_\_\_\_\_

#### NURSING

Infusion to be administered per Medica protocols.

☐ CBC ☐ at each dose ☐ every \_\_\_\_\_  
☐ CMP ☐ at each dose ☐ every \_\_\_\_\_  
☐ CRP ☐ at each dose ☐ every \_\_\_\_\_  
☐ OTHER \_\_\_\_\_

#### QUTENZA THERAPY ADMINISTRATION

☐ 1 patch of 8% capsaicin (280 mcg per cm<sup>2</sup>) every 91 days  
☐ 2 patches of 8% capsaicin (560 mcg per cm<sup>2</sup>) every 91 days  
☐ 3 patches of 8% capsaicin (840 mcg per cm<sup>2</sup>) every 91 days  
☐ 4 patches of 8% capsaicin (1120 mcg per cm<sup>2</sup>) every 91 days

#### LOCATION OF PATCH AND APPLICATION TIME

☐ Left Foot (Dx: Diabetic Peripheral Neuropathy: 30 minute application)  
☐ Right Foot (Dx: Diabetic Peripheral Neuropathy: 30 minute application)  
☐ Right Side (Dx: Post Herpetic Neuralgia: 60 minute application)  
☐ Left Side (Dx: Post Herpetic Neuralgia: 60 minute application)

#### PRE MEDICATIONS

☐ Acetaminophen (Tylenol) ☐ 500 mg ☐ 650 mg ☐ 1000 mg 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: \_\_\_\_\_

Dose: \_\_\_\_\_ Route: \_\_\_\_\_

#### REQUIRED DOCUMENTATION

☐ Patient Demographics  
☐ Insurance Card/Information  
☐ Progress Notes Supporting  
☐ DX Medication List and H&P  
☐ Capsaicin 8% Topical System Procedure Notes

*\*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.*

*\*\*Order is valid for one year unless otherwise noted\*\**

#### PRESCRIBER INFORMATION

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider's name: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician NPI: \_\_\_\_\_ Physician's DEA: \_\_\_\_\_

#### PLEASE SELECT PREFERRED PATIENT LOCATION:

- ☐ 105 Commerce St, # 109, Lake Mary, FL 32746
- ☐ 4850 W Oakland Park Blvd, #104, Lauderdale Lakes, FL 33313
- ☐ 3401 PGA Blvd, STE 540, Palm Beach Gardens, FL 33410
- ☐ 5210 Linton Blvd, STE 207, Delray Beach, FL 33484
- ☐ 3654 SW 30th Ave, Palm City, FL 34990

#### PLEASE FAX ORDER TO:

**Fax: 561-207-7848**

Phone: 689-488-1430  
info@medicainfusion.com  
www.medicainfusion.com