



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____	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: _____
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**CLINICAL INFORMATION**

<input type="checkbox"/> E08.40 Diabetes mellitus due to underlying condition w/ diabetic neuropathy, unspecified <input type="checkbox"/> E10.40 Type 1 diabetes mellitus with diabetic neuropathy, unspecified <input type="checkbox"/> E11.40 Type 2 diabetes mellitus with diabetic neuropathy, unspecified <input type="checkbox"/> B02.23 Postherpetic polyneuropathy <input type="checkbox"/> Other: _____	<input type="checkbox"/> E08.42 Diabetes mellitus due to underlying condition w/ diabetic polyneuropathy <input type="checkbox"/> E10.42 Type 1 diabetes mellitus with diabetic polyneuropathy <input type="checkbox"/> E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy <input type="checkbox"/> B02.29 Other postherpetic nervous system involvement
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**DRUG ORDERS**

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

Medication	Dose/Frequency	Quantity	Refills
<input type="checkbox"/> Qutenza (capsaicin 8% patch)	<input type="checkbox"/> 2 patches of 8% capsaicin (640 mcg per cm2) every 3 months <input type="checkbox"/> 3 patches of 8% capsaicin (640 mcg per cm2) every 3 months <input type="checkbox"/> 4 patches of 8% capsaicin (640 mcg per cm2) every 3 months <input type="checkbox"/> Other: _____	<input type="checkbox"/> 2 patches <input type="checkbox"/> 3 patches <input type="checkbox"/> 4 patches <input type="checkbox"/> _____	

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

**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.

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