Qutenza (8% Capsaicin)

Provider Order Form *rev. 1/12/2026*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

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

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

☐ NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description

Postherpetic Neuralgia-PHN
☐ B02.23 Postherpetic polyneuropathy
☐ B02.29 Other postherpetic nervous system involvement

Diabetic Peripheral Neuropathy- DPN of the feet
☐ E11.40 Type 2 diabetes mellitus with diabetic neuropathy, unspecified
☐ E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy
☐ E10.40 Type 1 diabetes mellitus with diabetic neuropathy, unspecified
☐ E10.42 Type 1 Type 1 diabetes mellitus with diabetic polyneuropathy
☐ E08.40 Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified
☐ E08.42 Diabetes mellitus due to underlying condition with diabetic polyneuropathy
☐ Other: *(Provide full code & description)*
ICD-10 Code: _____
ICD-10 Description: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☐ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications
☐ Acetaminophen (Tylenol) ☐500mg ☐650mg ☐ 1000mgPO
☐ Cetirizine (Zyrtec) 10mgPO
☐ Loratadine (Claritin) 10mgPO
☐ Diphenhydramine (Benadryl) ☐25mg ☐50mg ☐ PO ☐ IV
☐ Methylprednisolone (Solu-Medrol) ☐40mg ☐125mg IV
☐ Other: _____ Dose: _____ Route: _____

Lab Orders
Required: Capsaicin 8% Topical System Procedure Notes
☐ Other: _____

Therapy Order (Select one):
☐ Dosing: 2 patches of 8% capsaicin (640 mcg per cm2) every 3 months
☐ Dosing: 3 patches of 8% capsaicin (640 mcg per cm2) every 3 months
☐ Dosing: 4 patches of 8% capsaicin (640 mcg per cm2) every 3 months
☐ Other: _____

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

☐ **Refills:** ☐ zero ☐6 months ☐12 months ☐ _____ *(Prescription valid for one year, unless otherwise indicated)*

Special Instructions: _____
_____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

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

Greater Houston Area F: 832.510.7824 P: 832.800.3213
McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc)**: F: 469.305.2361 P: 972.865.4454**

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