QUTENZA BENEFIT
REFERRAL FORM

DELIVERIT™ Infusion & Specialty
Phone +1.832.939.8137
Fax: +1.832.939.8128

Patient Demographic Information

(Or Attach Face Sheet from Patient Chart)

Patient Name		DOB		Gender	Male ☐ Female ☐	Weight	____lbs ☐ kg ☐
SSN		Phone		Allergies			
Address		City		State		Zip Code	

Patient Insurance Information

(Or Attach Copies of Patient's Insurance Card)

Primary Insurance		Name of the Insured		Relationship	
Member ID#		Group #		Insurance Phone #	
Secondary Rx Carrier		Rx ID #		Rx Group #	

CLINICAL INFORMATION

ICD-10 code		CPT Code		A list of codes may be found in the QUTENZA Reimbursement Guideline. It is the physician's responsibility to provide the correct code.

PRESCRIPTION INFORMATION

Qutenza™ (capsaicin) 8% patch	Quantity (cm)	Specialty Pharmacy Only (optional)
	# of Patches (280 cm2 per patch)	1- Patch Kit (carton includes 1 patch and cleansing gel) NDC #72512-928-01 2- Patch Kit (carton includes 2 patches and cleansing gel) NDC #72512-929-01

Prescriber Insurance Information

Prescriber Name		NPI#		Office #		Fax #	
Address		City		State		Zip Code	

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

☐ DAW (Dispense as written).

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.

Date

Prescriber's Signature

X_____

Please fax all information to (877)993-3548 or call (832)939-8128 for assistance