MyQutenzaCoverage

Benefit Request and Prescription Form

Qutenza® (capsaicin) 8% topical system

Phone: 1-855-802-8746
Fax: 1-855-454-8746
MyQutenzaCoverage.com
Hours: (M-F) 9 AM– 7 PM ET

Patient Information

Last	First	(MI)	Date of Birth	Sex ☐ Male ☐ Female
Street Address	City	ST	Zip	Phone (please provide home/cell/work, if available)
Patient's Initial Treatment? Yes No – If No, Date of Initial Treatment _____			Anticipated Treatment Date for This Referral:	

Medical Insurance - Primary

Plan Name	Phone
Member ID	Group #

Medical Insurance - Secondary

Plan Name	Phone
Member ID	Group #

Pharmacy Insurance- Primary

Member ID	BIN
PCN	Group #

Pharmacy Insurance - Secondary

Member ID	BIN
PCN	Group #

Prescriber Information

☐ Physician Office ☐ Hospital Outpatient ☐ Other Site of Service # _____

Prescriber's Full Name:	Practice Name	Practice Contact	
Address	City	ST	Zip
Phone	Fax	NPI Number (Required)	TAX ID Number (Required)

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% topical system	**Quantity (cm)**	**Specialty Pharmacy Only (optional)**
	# of Topical Systems (280 cm^2 per patch) _____	☐ **1**- Kit (carton includes 1 topical system and cleansing gel) NDC #72512-928-01 ☐ **2**- Kit (carton includes 2 topical systems and cleansing gel) NDC #72512-929-01

Prescriber's Signature [1]

Prescriber's Signature: _____ Date: _____

1Authorization for Release of Health Information: By signing this form, I represent to MyQutenzaCoverage that I have obtained all necessary Federal and state authorizations and consents from my patient to allow me to release health information to MyQutenzaCoverage and its contracted third parties. I authorize MyQutenzaCoverage to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan. Signature on this form also provides consent to contact this patient's insurance provider for this prescription on the prescriber's behalf.