

QUTENZA® (capsaicin) 8% Topical System Patient Chart Documentation

Last Name		First Name			Date	Chart #
Date of Next Office Visit	BP ____/____	Pulse _____	A1C _____	Height ____' ____"	Weight _____	

Patient History

1. Date of prior capsaicin 8% topical system treatment ____ 1st Date ____ 2nd Date ____ 3rd Date ____ 4th Date							
2. Please identify the main area(s) of pain on the body: _____							
Which Side? <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral							
3. Please check the appropriate boxes below to identify the main area(s) of pain on the foot (feet):							
<input type="checkbox"/> Left Foot				<input type="checkbox"/> Right Foot			
<input type="checkbox"/> Anterior	<input type="checkbox"/> Posterior	<input type="checkbox"/> Plantar	<input type="checkbox"/> Proximal	<input type="checkbox"/> Anterior	<input type="checkbox"/> Posterior	<input type="checkbox"/> Plantar	<input type="checkbox"/> Proximal
<input type="checkbox"/> Dorsal	<input type="checkbox"/> Medial	<input type="checkbox"/> Lateral	<input type="checkbox"/> Distal	<input type="checkbox"/> Dorsal	<input type="checkbox"/> Medial	<input type="checkbox"/> Lateral	<input type="checkbox"/> Distal
4. Check the words that best describe the quality of your pain?							
<input type="checkbox"/> Aching	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Nagging	<input type="checkbox"/> Burning	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Gnawing	<input type="checkbox"/> Numb-like	<input type="checkbox"/> Tiring
<input type="checkbox"/> Shooting	<input type="checkbox"/> Penetrating	<input type="checkbox"/> Sharp	<input type="checkbox"/> Unbearable				
5. Please provide the patient's baseline Numeric Pain Rating Scale Score: _____				Please provide the patient's current Numerical Pain Rating Scale (NPRS) score: _____			

(A list of codes that may be appropriate can be found in the QUTENZA Reimbursement Guide.)

Coding: It is solely the healthcare provider's responsibility to provide the correct indication and codes.)

<input type="checkbox"/> B02.23 Postherpetic polyneuropathy	<input type="checkbox"/> B02.29 Other postherpetic nervous system involvement
<input type="checkbox"/> E08.40 Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified	<input type="checkbox"/> E08.42 Diabetes mellitus due to underlying condition with diabetic polyneuropathy
<input type="checkbox"/> E10.40 Type 1 diabetes mellitus with diabetic neuropathy, unspecified	<input type="checkbox"/> E10.42 Type 1 diabetes mellitus with diabetic polyneuropathy
<input type="checkbox"/> E11.40 Type 2 diabetes mellitus with diabetic neuropathy, unspecified	<input type="checkbox"/> E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy
<input type="checkbox"/> E13.40 Other specified diabetes mellitus with diabetic neuropathy, unspecified	<input type="checkbox"/> E13.41 Other specified diabetes mellitus with diabetic mononeuropathy
<input type="checkbox"/> E13.42 Other specified diabetes mellitus with diabetic polyneuropathy	<input type="checkbox"/> 3044F Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM)
<input type="checkbox"/> 3051F Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM)	<input type="checkbox"/> 3052F Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)
<input type="checkbox"/> 3046F Most recent hemoglobin A1c level greater than 9.0%	<input type="checkbox"/> Other: _____

<input type="checkbox"/> J Code: J7336	<input type="checkbox"/> J Code: J7336JW	<input type="checkbox"/> J Code: J7336JZ	<input type="checkbox"/> NDC # 72512-928-01 One (1) Single use topical system	<input type="checkbox"/> NDC # 72512-929-01 Two (2) Single use topical system(s)	<input type="checkbox"/> NDC # 72512-930-01 Four (4) Single use topical system(s)
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CPT Code: _____ E&M Code: _____ It is solely the healthcare provider's responsibility to select the most appropriate code.

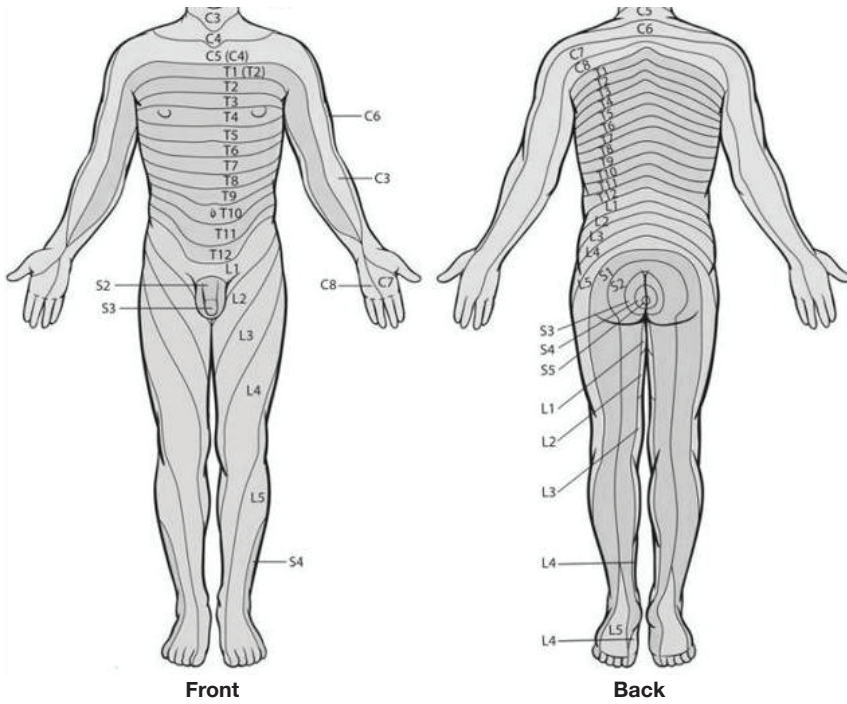
Capsaicin 8% Topical System Applied: (each unit is 1 cm²)

<input type="checkbox"/> 1 topical system (280 billing units)	<input type="checkbox"/> 2 topical systems (560 billing units)	<input type="checkbox"/> 3 topical systems (840 billing units)	<input type="checkbox"/> 4 topical systems (1120 billing units)
<input type="checkbox"/> Other ____/____ topical system (patch[es]) billing units	<input type="checkbox"/> Wastage ____/____ topical system (patch[es]) billing units		
<i>If Applicable</i>	System Lot #	Exp Date	

Additional Notes:

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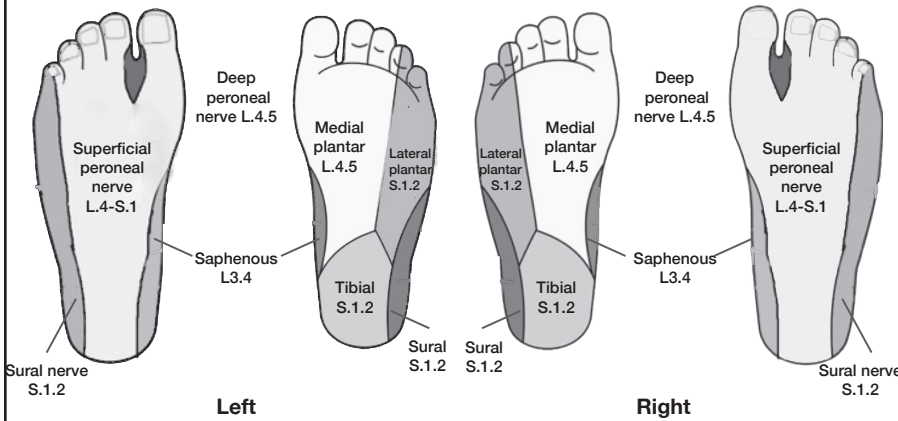
Please shade the area where the patient feels pain:
Average pain score (0 - 10 scale): _____



Patient has tried and failed and/or did not tolerate the following:

- Gabapentin
- Amitriptyline
- Clomipramine
- Doxepin
- Imipramine
- Trimipramine
- Amoxapine
- Desipramine
- Nortriptyline
- Protriptyline
- Lidocaine 5% patches
- Duloxetine
- Pregabalin
- Capsaicin topical analgesic cream
- Opioids (specify) _____
- Other _____

Please shade the area where the patient feels pain:
Average pain score (0 - 10 scale): _____



Additional Clinical Rational

ER Visits (#): _____

Other:

Provider's Signature _____

Date _____