Qutenza®
(capsaicin) 8% patch

For assistance please contact:
QUTENZA Reimbursement Support Services
Phone: **1-877-900-6479**, Option 3
Hours of operation: M–F, 8 AM– 7 PM (ET)

Reimbursement Support Form and Prescription for QUTENZA

Fax completed form to: 1-877-304-1045

Patient Information

Please attach an enlarged copy of the front and back of the patient's insurance card and/or other insurance information along with the form.

Patient Name (Last)	(First)	(MI)	Date of Birth:	Sex: ☐ Male ☐ Female

Street Address:	City:	State:	ZIP:	Phone (please provide home/cell/work, if available):

Patient's Initial Treatment?	Anticipated Treatment Date for This Referral:
☐ Yes ☐ No – If No, Date of Initial Treatment: _____	

Insurance Information

Primary Insurance:	Insurance Phone Number:	Insured and Relationship to Patient:

Member ID:	Group ID:	Copies of Insurance Cards attached ☐ Yes ☐ No

Secondary Insurance:	Secondary Insurance Phone Number:	Secondary Member ID:	☐ Patient has no coverage for prescription drugs

Communication with the Patient

It is our standard process to call the patient throughout various points of the process. Please check the appropriate box below so QUTENZA Reimbursement Support Services (QRSS) staff understands your preferences regarding communication with your patient.

☐ Yes - QUTENZA Reimbursement Support Case Manager may contact my patient.
☐ No - QUTENZA Reimbursement Support Case Manager may NOT contact my patient. My office will provide follow-up with the patient.

Prescriber Information

☐ Physician Office (#11) ☐ Hospital Outpatient (#22) ☐ Other Site of Service # _____

Prescriber's Full Name:	Office/Site/Clinic:	Office Contact:

Address:	City:	State:	ZIP:

Phone:	Fax:	E-mail:

DEA Number (Required):	NPI Number (Required):	TAX ID Number (Required):	PTAN Number (Required):

Patient Diagnosis

☐ B02.23 Postherpetic polyneuropathy ☐ B02.29 Other postherpetic nervous system involvement ☐ Other (specify) _____

The above ICD-10-CM codes do not represent an exhaustive list; providers are responsible for selecting the most appropriate diagnosis code(s) for a specific patient.

Application Coding

QRSS will determine if this patient's plan has established any coding requirements for the QUTENZA application procedure. If plan-specific requirements have NOT been established, QRSS will investigate 64999 and E&M/office visit codes.

☐ 64999 and E&M office visits codes only ☐ Other (specify CPT code and descriptor):_____

Prescription Information

Product Name:
QUTENZA (capsaicin) 8% patch

Order in Number of Kits: _____ ☐ 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

Medical Necessity

☐ Statement of Medical Necessity: QUTENZA is medically necessary for the above-referenced patient. It is my intention to treat the above-referenced patient with QUTENZA therapy, a drug indicated for the management of neuropathic pain associated with postherpetic neuralgia (PHN). It is my opinion that QUTENZA therapy is the most appropriate treatment available for the above-referenced patient. I verify that the patient and prescriber information contained in this enrollment form are complete and accurate to the best of my knowledge and that I have prescribed QUTENZA based on my professional judgment of medical necessity. Once approved by me, I authorize Averitas Pharma, Inc, or its affiliated companies or subcontractors to forward this prescription electronically, by facsimile, or by mail to a dispensing pharmacy. I also authorize QRSS to obtain reimbursement for QUTENZA including, but not limited to, insurance verification and case assessment. I understand that QRSS may need additional information, and I agree to provide it as needed for the purposes of reimbursement.

Prescriber's Full Signature: Date:

(No Stamps or Initials)

Please see Important Safety Information on last page.

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Instructions for Completing the QUTENZA Reimbursement Support Form

Phone: 1-877-900-6479, Option 3 **Fax:** 1-877-304-1045

Please write legibly and complete all required fields to prevent delays.
This instruction sheet may be used for guidance to assist in the completion of the form.

1. Collect Patient Information

Please provide the following information:

- ☐ Demographic Information, including Name, Address, Phone Number
- ☐ Date of Birth
- ☐ Patient Last Day of Treatment or Initial Treatment

Insurance information, including enlarged copies of patient's insurance cards:

- ☐ Primary Insurance
- ☐ Secondary Insurance

Communication with Patient:

- ☐ Sharing information regarding your patient's benefits

2. Complete Healthcare Provider Information

Please provide the following information:

- ☐ Demographic Information, including Name, Address, Phone Number, and Site of Service
- ☐ Office Contact Name and Telephone Number
- ☐ License and Provider Numbers

3. Complete Treatment Information

Please provide the following information:

- ☐ Provide the ICD-10-CM Code
- ☐ Provide Application Codes
- ☐ Complete and sign the prescription

4. Sign Statement of Medical Necessity and Authorization to Release Patient Information

The authorization allows the QUTENZA Reimbursement Support Services (QRSS) to investigate the patient's insurance coverage acting on behalf of the physician.

In order for the program to provide benefits investigation and reimbursement services, we must be authorized to use patient information. The requirement may be satisfied by the patient completing a HIPAA Authorization to Disclose Information form or by the HCP's office executing a Business Associate Agreement (BAA) with Premier Source, the administrator of QRSS. The HIPAA Authorization to Disclose Information form and the BAA can be downloaded from the QUTENZA website at www.qutenza.com.

5. Fax completed form to: 1-877-304-1045

6. QRSS will fax a benefits investigation document to your office for you to determine next steps.

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Indication:
QUTENZA® (capsaicin) 8% Patch is indicated for the management of neuropathic pain associated with postherpetic neuralgia.

IMPORTANT SAFETY INFORMATION:
Only physicians or healthcare professionals under the close supervision of a physician are to administer QUTENZA.

Contraindications:
None

Warnings and Precautions:
- Do not apply QUTENZA to the face or scalp to avoid risk of exposure to the eyes or mucous membranes.
- Aerosolization of capsaicin can occur and inhalation may result in coughing or sneezing.
- If skin not intended to be treated comes into contact with QUTENZA, clean area using Cleansing Gel.
- Patients may experience substantial procedural pain. Prepare to treat pain with local cooling (such as a cold pack) and/or appropriate analgesic medication.
- Transient increases in blood pressure may occur during and shortly after the QUTENZA treatment. Blood pressure changes were associated with treatment-related increases in pain. Monitor blood pressure and provide adequate support for treatment-related pain. Patients with unstable or poorly controlled hypertension or a recent history of cardiovascular or cerebrovascular events may be at an increased risk of adverse cardiovascular effects. Consider these factors prior to initiating QUTENZA treatment.
- If opioids are used to treat pain associated with the application procedure, please note that opioid treatment may affect the patient's ability to perform potentially hazardous activities such as driving or operating heavy machinery.

Adverse Reactions:
In clinical trials, serious adverse reactions included application associated pain and increase in blood pressure. The most common adverse reactions (≥ 5% and greater than control) were application-site erythema, application-site pain, application-site pruritus, or application-site papules, and nausea.

To report an adverse event, you can visit www.fda.gov/medwatch or call 1-800-FDA-1088; or you can call Averitas Pharma, Inc. at 1-877-900-6479.

Please see full Prescribing Information.

AveritasPharma™

M-QZA-US-10-19-0019 November 2019