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

MQC
My Qutenza Connect

COST SAVINGS PROGRAM ENROLLMENT FORM

HEALTHCARE PROVIDER OR PHARMACY INFORMATION	
HCP or Pharmacy Name	
HCP or Pharmacy NPI	
Phone Number	

STEP 1

To receive payment for the benefit of, and on behalf of, your patient in an amount equal to your eligible patient's medication and/or administration copayment, coinsurance, or deductible costs for those claims for QUTENZA covered under the medical benefit as "buy-and-bill," the following information is required:

QUTENZA PRESCRIPTION INFORMATION			
Date of Application or Fill Date		Quantity of Topical Systems to be applied (one topical system equals 280 cm^2)	
QUTENZA NDC		Billable Units (one topical system has 280 units)	
Patient Responsibility	$	Days' Supply	90-day treatment
Rx Group	OH0101011	Rx ID	L94100186238

QUTENZA ADMINISTRATION INFORMATION			
CPT Code		Patient Responsibility	$

PATIENT INFORMATION			
First Name		Last Name	
Address		City	
State		ZIP Code	
Date of Birth		Gender Assignment	☐ Male ☐ Female

STEP 2

Please sign the Certification Statement below and fax the following documents along with this completed form to **1-631-822-2893** or mail to Attn: Claims Processing Department; IQVIA, Inc. 77 Corporate Drive; Bridgewater, NJ 08807. Please see QUTENZA.com for additional details.

PAYMENTS WILL NOT BE PROCESSED WITHOUT THE BELOW ITEMS:

- **Completed QUTENZA Patient Cost Savings Program Enrollment Form and Signed Certification Statement (this form)**
- **Patient Explanation of Benefits (EOB) Form or Remittance Form**
- **HCFA or CMS 1500 Form**

Certification Statement

I certify that the information provided herein is accurate; that expenses requested for payment are eligible (consistent with program terms and conditions) US patient copay, coinsurance, or deductible expenses, actually incurred, and not paid by the patient's insurance, Flexible Spending Account, Health Savings Account, or any other payer; and that I would, in the ordinary course of my practice, have charged my patient for such out-of-pocket expenses. I also certify that the above-referenced patient (i) is not purchasing their QUTENZA prescriptions with benefits from Medicare, including Medicare Part D or Medicare Advantage Plans; Medicaid, including Medicaid Managed Care or Alternative Benefit Plans (ABPs) under the Affordable Care Act; Medigap; Veterans Administration (VA); Department of Defense (DoD); TRICARE®; or any similar state-funded programs such as medical or pharmaceutical assistance programs; and (ii) meets the other eligibility criteria specified under Step 1 above. I understand that I am liable for any misrepresentations herein to the full extent of applicable law. I certify that the above therapy is medically necessary and that this information is accurate to the best of my knowledge. Further, I have not and will not seek payment from other sources. My signature certifies that I am the physician or pharmacist who has prescribed or filled the selected drug to the patient identified above. Please see QUTENZA.com for additional details.

Acknowledged and Agreed: _____ **Date:** _____

For assistance with this form, contact IQVIA at 1-833-295-3579. Please allow 2–4 weeks for processing claims. Successful claims will be processed and paid in the subsequent billing cycle.

Qutenza®
(capsaicin) 8% topical system