MQC
My Qutenza Connect

BENEFIT REQUEST AND PRESCRIPTION FORM

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

Case ID: _____
Received: _____

PATIENT INFORMATION

Last Name	First Name	MI	Sex Assignment[1] ☐ Male ☐ Female	Date of Birth	Phone

Street Address	City	State	ZIP	Email

Patient's Initial Treatment?	☐ Yes ☐ No – If No, Date of Initial Treatment:	Allergies	Anticipated Treatment Date

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

Prescriber's Full Name	Practice Name	Practice Contact

Address	City	State	ZIP

Phone	Fax	NPI Number	TAX ID Number

CLINICAL INFORMATION

☐ Physician Office ☐ Hospital Outpatient ☐ Other Site of Service:

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

PRESCRIPTION INFORMATION

Qutenza® (capsaicin) 8% topical system

Quantity
# of Topical Systems (280 cm^2 billing units)
_____

Refills
_____

Fulfillment Options
- ☐ 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
- ☐ 4 Kit (carton includes 4 topical systems and Cleansing Gel) NDC #72512-930-01

HA1C Levels

☐ **Auto Transfer**
By checking this box, if Rx coverage is found, your prescription will be automatically transferred to a specialty pharmacy for fulfillment

Directions

Shipping Address (if different from above)

ATTACH THE PATIENT CHART AND / OR CLINICAL DATA WITH THE SUBMISSION OF THIS INTAKE FORM TO BEGIN THE PA PROCESS.

PRESCRIBER'S SIGNATURE[2]

☐ Automatically re-investigate patient for potential retreatment in 91 days

Prescriber's Signature: _____ **Date:** _____

1. Gender override edits may be permissible by payer.
2. Authorization for Release of Health Information: By signing this form, I represent to My QUTENZA Connect that I have obtained all necessary federal and state authorizations and consents from my patient to allow me to release health information to My QUTENZA Connect and its contracted third parties. I authorize My QUTENZA Connect 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. My signature on this form also provides consent to contact this patient's insurance provider for this prescription on the prescriber's behalf.

Qutenza® (capsaicin) 8% topical system