

# Capsaicin 8% Topical System Procedure Notes

Last Name	First Name	Date	Chart #
Date of Next Office Visit	BP _____/_____	Pulse _____	Height _____, _____ Weight _____

## Patient History

1. Date of prior Capsaicin 8% Topical System application _____ 1st Date _____ 2nd Date _____ 3rd Date _____ 4th Date			
2. Please identify the main area(s) that has 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"/> Dorsal	<input type="checkbox"/> Medial	<input type="checkbox"/> Lateral	<input type="checkbox"/> Distal
<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
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

## Coding: (Coverage Reimbursement Guide provides a list of codes. It is the physician's responsibility to provide the correct 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"/> Other: _____		
<input type="checkbox"/> J Code: J7336	<input type="checkbox"/> J Code: J7336JW	<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)
CPT Code: _____ *Please refer to billing and reimbursement guideline for additional billing information			

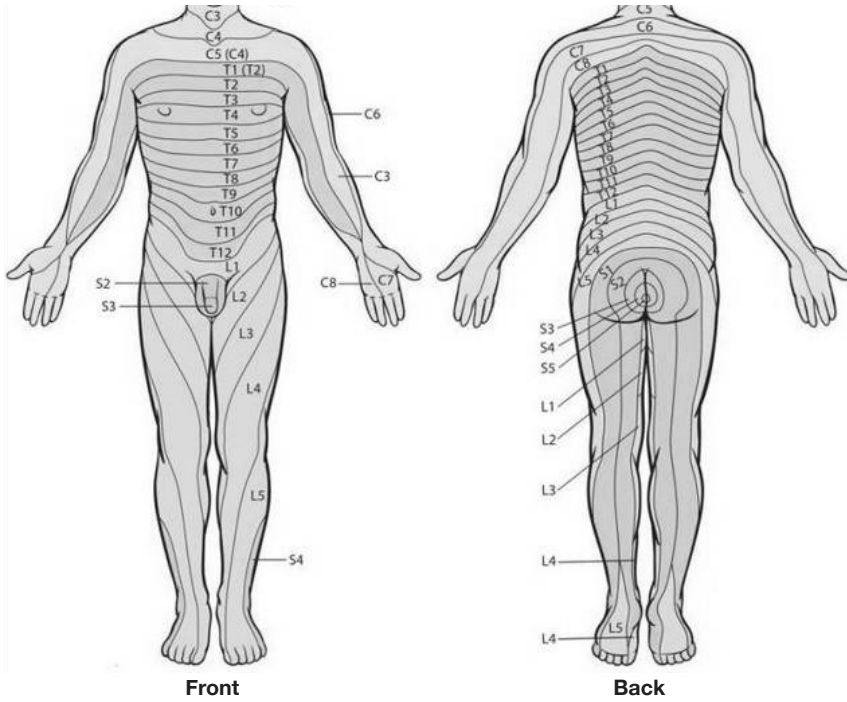
## Capsaicin 8% Topical System Applied: (each unit is 1cm<sup>2</sup>)

<input type="checkbox"/> 1 topical system (1 patch - 280cm <sup>2</sup> billing units)	<input type="checkbox"/> 2 topical systems (2 patches - 560cm <sup>2</sup> billing units)	<input type="checkbox"/> 3 topical systems (3 patches - 840cm <sup>2</sup> billing units)	<input type="checkbox"/> 4 topical systems (4 patches - 1120cm <sup>2</sup> 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 (patch) Lot#	Exp Date	

## Additional Notes:

# Capsaicin 8% Topical System Procedure Notes

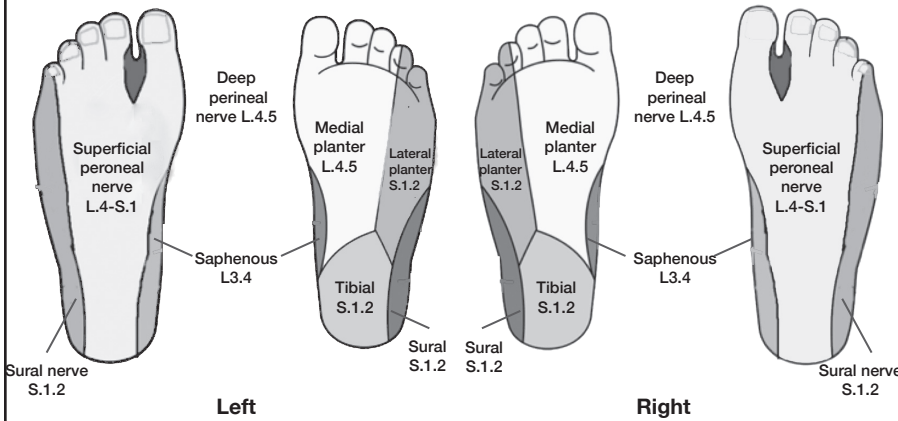
Please shade the area where the patient feels pain:  
Average pain score ( 0 - 10 scale ): \_\_\_\_\_



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

- Gabapentin
- Amitriptyline
- Clomipramine
- Doxepin
- Imipramine
- Trimipramine
- Amoxapine
- Desipramine
- Nortriptyline
- Protriptyline
- Lidocaine Patches
- Duloxetine
- Pregablin
- 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 \_\_\_\_\_