

**Zinplava (bezlotoxumab) ORDER FORM**

Prerequisites to treatment – ensure the following information is complete and attached with referral:  Demographics  Prior Authorization  Office/Progress Notes

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_  Male  Female

Phone Number: \_\_\_\_\_ Allergies: \_\_\_\_\_

**DIAGNOSIS**

Clostridium difficile infection ICD 10: \_\_\_\_\_

Other: \_\_\_\_\_ ICD 10: \_\_\_\_\_

**PRE-MEDICATION**

Tylenol 1000mg PO  Solu-Medrol 40mg IVP

Cetirizine 10mg PO  Solu-Medrol 125mg IVP

Diphenhydramine 25mg PO  Other: \_\_\_\_\_

**MEDICATION****Zinplava**

*Dosing:*  10mg/kg

*Duration:*  IV infusion over 60 minutes

*Frequency:*  Once

*Route:*  Peripheral IV per protocol  PICC capping per protocol  PORT capping per protocol

Monitor vitals baseline and post infusion

Other: \_\_\_\_\_

**REFERRING PROVIDER INFORMATION**

For questions regarding patient’s care during the infusion, please contact:

Facility: \_\_\_\_\_ Fax: \_\_\_\_\_

Name 1<sup>st</sup> Point of Contact (must be available during infusion): \_\_\_\_\_

Phone: \_\_\_\_\_

Name 2<sup>nd</sup> Point of Contact (must be available during infusion): \_\_\_\_\_

Phone: \_\_\_\_\_

*By referring to the Medical Associates Infusion Clinic, it is recognized and agreed upon that the referring specialist or delegate listed above will be available and responsive during the duration of the scheduled infusion appointment. This contact should be available to answer any questions and/or address concerns related to the care of the patient. The on-site provider within the Infusion Clinic will be responsible for urgent patient care needs during the infusion.*

Ordering Provider Name (please print): \_\_\_\_\_

Ordering Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FAX NUMBER: 563-584-4232**

**PHONE NUMBER: 563-584-4370**

Order valid for 1 year from date of signature unless otherwise specified.