

Zinplava IV Infusion Order

(Bezlotoxumab)



Ph: 805-719-3700 | Fax: 805-852-2636

Date: ____ / ____ / ____ Treatment Location: _____

***Please fax a copy of the following patient information:** Demographics Insurance Information Current Lab Results
 H & P Relevant to the Diagnosis and Rx Current Medications

PATIENT INFORMATION

Patient Name: _____

DOB: ____ / ____ / ____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ____ / ____ / ____

Phone: (____) ____ - ____ Fax: (____) ____ - ____

Office Address: _____

Contact Person: _____

ZINPLAYA (BEZLOTOXUMAB) DOSAGE:

25 mg/mL (1000 mg/40 mL) vial in 0.9% Normal Saline 250 mL 500 mL 1000 mL

Dosage: 10 mg/kg Start Date: ____ / ____ / ____

**Please send positive *C difficile* toxin B results.
Patient must be on C-diff antibiotics: vancomycin, metronidazole, fidaxomicin to infuse Zinplava**