# Zinplava

INFUSION FOR HEALTH
InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

**PROVIDERS: Please include the following to expedite the order.**

Demographics, Insurance Information, Current CBC & CMP
H & P Relevant to the Diagnosis, Current Medications, Positive C-diff Culture

## PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: ☐ A04.71 Enterocolitis due to Clostridium difficile

Other Dx/ICD10: _____

## PRESCRIBER INFORMATION

Prescriber's Name: _____

**Signature:** _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

**Center will use Hypersensitivity protocol established by Infusion for Health and P.I.**

## ZINPLAVA

Date of Last Treatment, If Continuation: _____

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

**Dosage:** ☐ 10 mg/kg **Frequency:** once **Route:** ☑ IV **Start Date:** _____

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

*To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar.*

☐ Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

☐ Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.