

# Bezlotoxumab (Zinplava)

Provider Order Form rev. 01/02/2024

## PATIENT INFORMATION

Referral Status:  New Referral  Updated Order  Order Renewal

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

Patient Address: \_\_\_\_\_ Patient Email: \_\_\_\_\_

Allergies: \_\_\_\_\_  NKDA Weight (lbs/kg): \_\_\_\_\_ Height (in/cm): \_\_\_\_\_

Sex:  M /  F Date of Last Infusion: \_\_\_\_\_ Next Due Date: \_\_\_\_\_ Preferred Location: \_\_\_\_\_

## DIAGNOSIS (Please provide ICD-10 code in space provided)

C. Diff infusion Prophylaxis: \_\_\_\_\_

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

## THERAPY ADMINISTRATION

Administer Zinplava 10mg/kg x \_\_\_\_\_ kg = \_\_\_\_\_ mg IV over 60mins one time. Dilute in NS or D5W to a final concentration of 1 to 10mg/ml. Do not shake

## ADDITIONAL ORDERS

## PRE-MEDICATION ORDERS

- Tylenol  500mg /  650mg PO
- Loratadine 10mg PO
- Pepcid 20mg  PO /  IVP
- Benadryl  25mg /  50mg  PO /  IVP
- Solumedrol  40mg /  125mg IVP
- Other: \_\_\_\_\_

## NURSING

- Hold infusion and notify provider for signs or symptoms of pre-existing congestive heart failure.
- MUST be used in conjunction with antibiotics
- Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

## PROVIDER INFORMATION

Preferred Contact Name: \_\_\_\_\_ Preferred Contact Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

**Required Documentation:** Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with Vancomycin and Flagyl, Risk factors, Number of infections, Clinical severity, Use caution in patients with CHF, benefits should outweigh the risks

**Required Labs:** C. Diff fecal within the last 7 days

\_\_\_\_\_  
Provider Name (print)

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date