BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

ZINPLAVA® (BEZLOTOXUMAB) INFUSION ORDERS

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT DEMOGRAPHICS

Patient Name: _____	DOB: _____	Phone: _____
Address: _____	City/ST/Zip: _____	
Allergies: _____	NKDA	Weight: _____ lbs kg / Height: _____ in cm

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

Enterocolitis due to *Clostridium difficile*, recurrent, A04.71

Enterocolitis due to *Clostridium difficile*, not specified as recurrent, A04.72

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Zinplava® (bezlotoxumab)	_____ mg (10 mg/kg)	Infuse IV over 60 minutes x 1 dose.

Has patient received therapy above from another facility?
Yes No

If yes, Facility Name: _____

Date of Last Treatment: _____ Date of Next Treatment: _____

PRE MEDICATION ORDERS

No premeds ordered at this time

Acetaminophen 650mg PO Diphenhydramine 25mg PO

Methylprednisolone 40mg IVP -OR- Hydrocortisone 100mg IVP

Other: _____

LAB ORDERS

Labs to be drawn by: Infusion Center Referring Physician

No labs ordered at this time

Blood glucose q _____ CBC with diff/platelet q _____

CMP q _____ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

The patient has active *C. difficile* infection (CDI), e.g., frequent watery stool (≥3 per day), abdominal pain, fever, and/or nausea.

Current CDI episode is confirmed with a positive stool test for *C. difficile* toxin. ***(Attach copy of test result.)***

- Date stool sample collected: _____

The patient will be receiving standard of care antibacterial drug therapy for the treatment of CDI in conjunction with Zinplava®.

Specify current antibacterial therapy:

Antibacterial therapy for CDI	Dose	Route	Frequency	Date Started	Anticipated Stop Date
Fidaxomicin (Dificid®)					
Vancomycin					
Metronidazole					

The patient is at high risk of CDI recurrence. ***Select all that apply:***

Age ≥65 years
History of CDI in the past 6 months
Immunocompromised state
Long-term use of systemic antibiotics
Severe CDI at presentation (e.g., ZAR score ≥2)
Hypervirulent strain of *C. difficile* (ribotype 027, 078 or 244)
Other: _____

Patient has had prior episode(s) of CDI.

- Number of previous CDI episode(s) within the last year: _____
- Date(s) of previous CDI episode(s) within the last year: _____

LAB AND TEST RESULTS (required)

Positive *C. difficile* stool test

PRIOR FAILED THERAPIES FOR CDI

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____