Zinplava®

Provider Order Form Rev. 07/2023

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

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.

- 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 antibacterial therapy for current CDI:

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: _____