

**ZINPLAVA (bezlotoxumab)
INFUSION ORDERS**

****REQUIRED INFORMATION****

- This signed order form from the provider
- Patient demographics & insurance information
- Clinical/Progress Notes, Positive C-Diff test, Documentation that Patient is actively on CDI Antibiotic treatment.**

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis:

- A04.71 Enterocolitis due to Clostridium difficile, recurrent
- A04.72 Enterocolitis due to Clostridium difficile, not specified as recurrent

ZINPLAVA ORDERS

Zinplava Dose

- 10mg/kg dose administered as an IV infusion over 60 minutes Patient weight _____ kg

Pre-Medication Orders: Tylenol 650mg PO, *please choose one antihistamine:*

- Cetirizine 10mg PO
- Diphenhydramine 25mg PO
- Loratadine 10mg PO
- Other _____

****Patient MUST be on CDI antibiotic treatment at the time of infusion****

Physician Name:	Phone:	Fax:
**Physician Signature:	Date:	