INTRAMED Plus
infusion services

ZINPLAVA®

INFUSION & MEDICAL CENTER

1. ______________________________ ______________ ______________________
Patient Name **DOB** **Patient Phone/Cell #**

Patient demographic and insurance information to be faxed with Infusion Order Form

2. **Medical Information (Please complete/select appropriate diagnsosis):**

Primary Diagnosis: ______Enterocolitis due to C. difficile, recurrent ICD-10 Code: A04.71

______Enterocolitis due to C. difficile, not specified as recurrent ICD-10 Code: A04.72

Allergies:____(or attach list)

3. **Clinical Information – Please fax with Infusion Order Form:**

- Clinical MD Notes, labs, test supporting primary diagnosis
- Copy of prescription for concurrent antibacterial therapy

Patient
Weight: __________ lbs.
Height:__________ in.

ZINPLAVA® (bezlotoxumab) J Code: J0565

4. **Drug Order:**

Zinplava (bezlotoxumab): ❑ ________ mg or ❑ 10 mg/kg

Administer one dose IV over an hour

Pre-Medication Orders: Acetaminophen 650 mg PO
Administered 30 min prior to infusion *Adjust to patient's needs

❑ Other:____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus
to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. **Physician Signature:** ____________________ / ____________________ Date: __________
Dispense as written Substitution permitted

Printed Physician's Name:______________________________Contact Phone #: ________________

FAX ALL INFORMATION **CENTRAL FAX 803.999.1754** **ALTERNATE FAX 803.999.1887**	**INFUSION CENTER LOCATIONS** **COLUMBIA CHARLESTON GREENVILLE** **CENTRAL INTAKE PHONE 800.767.6337**

NOV 2019