Zinplava IV Infusion Order
(Bezlotoxumab)

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

www.smartchoiceinfusion.com
Ph: 818-659-8182
Fax: 818-659-8990

Date: ____________ Treatment Location: ____________

*Please fax a copy of the following patient information:
❒ Demographics ❒ Insurance Information ❒ Current CBC & CMP
❒ H & P Relevant to Diagnosis ❒ Current Medications
❒ Positive C-diff Culture

PATIENT INFORMATION

Patient Name: ____________

DOB: ____________

Allergies: ____________

Weight: ________ ◯ lbs / ◯ kg Height: ________

Diagnosis: ____________

ICD-10: ____________

PROVIDER INFORMATION

Printed Provider's Name: ____________

Signature: ____________

NPI: ________ Date: ________

Phone: ________ Fax: ________

Office Address: ____________

Contact Person: ____________

Contact Email: ____________

ZINPLAYA IV (BEZLOTOXUMAB) DOSAGE:

Date of Last Treatment, If Continuation:

25 mg/mL (1000 mg/40mL) vial in 0.9 Normal Saline ❒ 250 mL ❒ 500 mL ❒ 1000 mg

Dosage: ❒ 10 mg/kg Start Date: ____________

Please send positive C diffile toxin B results.
Patient must be on C-diff antibiotics: vancomycin, metronidazole, fidaxomicin to infuse Zinplaya