MIC | METRO INFUSION CENTER

MEDICATION ORDERS- ZINPLAVA (BEZLOTOXUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/

Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
☐ *C. Difficile* Infection	ICD 10 Code: A04.72

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider ☐ Patient demographics AND insurance information ☐ *C. Difficile* stool testing	☐ Clinical/Progress notes ☐ Labs and Tests supporting primary diagnosis
Please indicate the patient's current antibiotic treatment for *C. Difficile* infection, which will be continued during Zinplava treatment:	

MEDICATION ORDERS	
Dosing	☐ Zinplava 10mg/kg IV once

PRESCIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

Send a referral via fax at 866-507-1164 or email to the MICreferral@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.