Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: _____ Patient D.O.B._____/_____/_____

Patient Phone # (_____) _____-_____ Gender_____

Patient Address _____

City_____ State _____ Zip Code_____

Referring Provider (Please Print) _____

Office Phone # (_____) _____-_____ Office Contact: _____

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

Bezlotoxumab® (Zinplava) Treatment Plan

Patient Name: _____ **Patient DOB** _____/_____/_____

General

☐ Diagnosis- Enterocolitis due to *Clostridium difficile*, Recurrent ICD- A04.71

☐ Diagnosis - _____; ICD- _____

Pt Weight_____ Pt Height_____ Known Allergies_____

Requested Start Date: _____ /_____ /_____

Has patient previously received medication ☐ No ☐ Yes- If so, date of last infusion ____/____/_____

Authorized Treatment Duration ☑ 1x dose

Infusion (Month 1 to 12) Duration: 12 Months

☑ Vital Signs (Month 1 to 12)

every 30 min, including RR, BP, HR, 02 sat and temperature on admission, as well as RR, HR, BP and O2 sat every 30 minutes during the infusion and prior to discharge.

Pre-Treatment

Acetaminophen (Month 1 to 12)

☐ *650 mg, Oral, Tab, Day of Tx*

Comments: Administer 30 minutes before dose

Diphenhydramine (Month 1 to 12)

☐ *25 mg, IV Push, Injection, Day of Tx*

Comments: Administer 30 minutes before dose

☐ *50 mg, IV Push, Injection, Day of Tx*

Comments: Administer 30 minutes before dose

Methylprednisolone (Month 1 to 12)

☐ *40 mg, IV Push, Powder-Inj, Day of Tx*

Comments: Administer 30 minutes before dose

☐ *125 mg, IV Push, Powder-Inj, Day of Tx*

Comments: Administer 30 minutes before dose

***Bezlotoxumab*® Single Dose**

☐ 10mg/kg, IV, Piggyback, Once

Comments: In NS to 250mL. Infuse over 60 minutes using a sterile, nonpyrogenic, low-protein binding 0.2 – 5 micron in-line or add-on filter.

☑ Pharmacy may round dose to nearest 50mg (dose adjustment not to exceed 10%)

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____**Provider Name (please print)**_____

Date_____**/**_____**/**_____

Bezlotoxumab® (Zinplava) Treatment Plan

☑ INF Infusion Room Orders Subphase (Month 1 to 12)

☑ Communication Order (Month 1 to 12

Nursing to check vital signs prior to and following administration as well as monitor patient for 30 minutes after injection.

☑ Notify Provider (Month 1 to 12)

Verify that patient is on oral antibiotic therapy at time of infusion. Bezlotoxumab® is not intended to be monotherapy. If patient is not taking oral antibiotic therapy, call ordering physician prior to initiating infusion.

☑ Notify Provider (Month 1 to 12)

For chills, chest pain, dyspnea, pruritic, urticaria, persistent flushing, or temperature > 100 F

HR >130 or <50bpm
SBP >160 or <90 mmHg
DBP >110 or <50 mmHg

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ DOB _____/_____/_____