Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071

ADULT AMBULATORY INFUSION ORDER

Alglucosidase alfa (LUMIZYME)

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note.**
2. Alglucosidase alfa is part of **FDA REMS Program**
    a. Prescribers MUST be enrolled in the Lumizyme Program to prescribe Lumizyme (alglucosidase alfa)
    b. Patients MUST be enrolled in the Lumizyme Program
    c. Please see reference links below for enrollment forms and additional help
        i. http://www.lumizyme.com/healthcare/lumizyme_ace_program.aspx
        ii. http://www.lumizyme.com/~/media/LumizymeUS/Files/lumizyme_physician_enrollment_andattestation_form.pdf
        iii. http://www.lumizyme.com/~/media/LumizymeUS/Files/lumizyme_patient_enrollment_and_acknowledgement_form.pdf
        iv. http://www.lumizyme.com/~/media/LumizymeUS/Files/lumizyme_infusion_confirmation_form.pdf
    d. Provider or Healthcare professional administering drug MUST complete the Lumizyme Infusion Form and fax in to Gemzyme
3. Ordering Instructions for Pharmacy Services
    a. Pharmacy MUST fill out the Lumizyme Infusion Form and complete section one and send with medication to the floor for administration
    b. Do NOT borrow from any other pharmacies

LABS:

NURSING COMMUNICATION – Patients should be monitored for IgG antibody formation every 3 months for 2 years and then annually thereafter. Testing for IgG titers may also be considered if patients develop allergic or other immune mediated reactions. Patients who experience anaphylactic or allergic reactions may also be tested for IgE antibodies to alglucosidase alfa and other mediators of anaphylaxis

☐ IgG antibody ONCE every 3 months for 2 years, and then ONCE every year.
☐ Labs already drawn. Date: _____

MEDICATIONS:

- Alglucosidase alfa (LUMIZYME) **20 mg/kg** in NaCl 0.9% 500 mL, intravenous, EVERY 2 WEEKS, at least 10 days apart. *(Pharmacist to round dose for vial size)*
    - Administer without delay post-prep, using in-line low protein binding 0.2 micrometer filter
    - Refer to nursing orders for infusion instructions. Start infusion no more than 1 mg/kg/hr. May increase by 2 mg/kg/hr every 30 minutes as tolerated to a maximum of 7 mg/kg/hr
    - Refrigerate and protect from light; do not infuse with other IV products.
- NaCl 0.9% 50 mL, intravenous, Flush following infusion. Administer using the final infusion rate.

NURSING ORDERS:

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1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
2. Infusion Line Preparation: Prime the infusion line with the infusion solution via gravity to minimize bubbles within the infusion line. Alglucosidase alfa (LUMIZYME) should NOT be infused in the same line with other products.
3. Contact IV therapy to start IV. Prepare for infusion by warming patient with warm blankets and hand warmers for 10 minutes.
4. Alglucosidase alfa (LUMIZYME) 20 mg/kg will be administered in a step-wise manner, beginning at an initial rate of 1 mg/kg/hr and increasing by 2 mg/kg/hr every 30 minutes (if there are no signs of infusion-associated reactions (IARs), until a maximum rate of 7 mg/kg/hr is reached.
5. DO NOT PRE-PROGRAM PUMP FOR AUTOMATIC TITRATIONS!
   MUST FILL IN BELOW BASED ON PATIENT WEIGHT
   Step 1: 1 mg/kg/hr (_____ mL/hr) administered over 30 mins - If no signs of IARs, go to next step
   Step 2: 3 mg/kg/hr (_____ mL/hr) administered over 30 mins - If no signs of IARs, go to next step
   Step 3: 5 mg/kg/hr (_____ mL/hr) administered over 30 mins - If no signs of IARs, go to next step
   Step 4: 7 mg/kg/hr (_____ mL/hr) administered over 30 mins - If no signs of IARs, complete infusion at this rate
6. VITAL SIGNS
   a. Immediately prior to infusion
   b. Every 30 minutes during infusion
   c. Immediately prior to any infusion rate change
   d. Upon completion of the infusion

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction

AS NEEDED MEDICATIONS:

1. Albuterol (PROVENTIL, VENTOLIN) 90 mcg/actuation inhaler, 2-4 puffs, every 10 Minutes AS NEEDED for bronchospasm

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By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

OLC Central Intake Nurse:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient's preferred clinic location:

☐ **Beaverton**
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ **NW Portland**
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ **Gresham**
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ **Tualatin**
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders