ADULT AMBULATORY INFUSION ORDER

Avalglucosidase Alfa (NEXVIAZYME) Infusion

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. Life-threatening hypersensitivity reactions, including anaphylaxis, and severe infusion-associated reactions (IARs) have occurred in some patients during and after avalglucosidase alfa infusions. Patients with an acute underlying illness at the time of infusion may be at greater risk for IARs. Patients with advanced Pompe disease may have compromised cardiac and respiratory function, which may predispose them to a higher risk of severe complications from IARs. Inform patients of the signs and symptoms of anaphylaxis, hypersensitivity reactions, and IARs and have them seek immediate medical care should signs and symptoms occur.

LABS:

- CK, Plasma, ONCE, every 8 weeks
- Liver set (AST, ALT, BILI TOTAL, BILI DIRECT, ALK PHOS, ALB, PROT TOTAL), ONCE, every 8 weeks
- Hex4, Urine, ONCE, every 8 weeks
- Anti-Avalglucosidase Alfa (NEXVIAZYME) antibody to Labcorp-Sanofi Genzyme, ONCE, every 8 weeks

NURSING ORDERS:

1. Vital signs at baseline, prior to each infusion rate increase, and following infusion.
2. Actual Body Weight ≥30 kg: Avalglucosidase alfa (NEXVIAZYME) 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.
   a. Initial and Subsequent Infusions-DO NOT PRE-PROGRAM PUMP FOR AUTOMATIC TITRATIONS!
      Step 1: 1 mg/kg/hr (0.25 mL/kg/hr) administered over 30 mins - If no signs of IARs, go to next step
      Step 2: 3 mg/kg/hr (0.75 mL/kg/hr) administered over 30 mins - If no signs of IARs, go to next step
      Step 3: 5 mg/kg/hr (1.25 mL/kg/hr) administered over 30 mins - If no signs of IARs, go to next step
      Step 4: 7 mg/kg/hr (1.75 mL/kg/hr) administered over 30 mins - If no signs of IARs, complete infusion at this rate
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)

Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

☐ acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
☐ loratadine (CLARITIN) tablet, 10 mg, oral, ONCE, every visit

MEDICATIONS (must check one):
☐ Actual body weight ≥30 kg: Avalglucosidase alfa (NEXVIAZYME) 20 mg/kg in D5W, intravenous, ONCE, every 2 weeks
☐ Actual body weight <30 kg: Avalglucosidase alfa (NEXVIAZYME) 40 mg/kg in D5W, intravenous, ONCE, every 2 weeks

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, HMC C-132). 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
5. famotidine (Pepcid) injection, 20 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction

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