ADULT AMBULATORY INFUSION ORDER

**Alglucosidase alfa (LUMIZYME) 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 anaphylactic reactions and severe hypersensitivity reactions have occurred in some patients during and after alglucosidase alfa infusions. Immune-mediated reactions presenting as proteinuria, nephrotic syndrome, and necrotizing skin lesions have occurred in some patients following treatment. Inform patients of the signs and symptoms of anaphylaxis, hypersensitivity reactions, and immune-mediated reactions and have them seek immediate medical care should signs and symptoms occur.

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: __________

NURSING ORDERS:

1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
2. 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
   e. 1-hour post infusion
3. 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.
4. DO NOT PRE-PROGRAM PUMP FOR AUTOMATIC TITRATIONS!
   Step 1: 1 mg/kg/hr administered over 30 mins - If no signs of IARs, go to next step
   Step 2: 3 mg/kg/hr administered over 30 mins - If no signs of IARs, go to next step
   Step 3: 5 mg/kg/hr administered over 30 mins - If no signs of IARs, go to next step
   Step 4: 7 mg/kg/hr administered over 30 mins - If no signs of IARs, complete infusion at this rate
**MEDICATIONS:**
- Alglucosidase alfa (LUMIZYME) **20 mg/kg** in 0.9% sodium chloride 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.

**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 (OHSU 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 x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. Hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. Famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion 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.
Central Intake:
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