Oregon Health & Science University Hospital and Clinics Provider's Orders PO7071 ADULT AMBULATORY INFUSION ORDER **Agalsidase Beta (FABRAZYME) Infusion** Page 1 of 3	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. Indicated for use in patients with Fabry disease. Reduces globotriaosylceramide (GL-3) deposition in capillary endothelium of the kidney and certain other cell types
3. Please encourage patients to enroll in the Fabry registry by visiting www.fabryregistry.com or calling 1-800-745-4447.
4. Patients with advanced Fabry disease may have compromised cardiac function which may predispose them to a higher risk of severe complications from infusion reactions.

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 – Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion, with every rate increase, then hourly until infusion is complete.
3. Initial infusion: Rate should not exceed 15 mg/hr. Subsequent infusions if no infusion reactions: rate may be increased in increments of 3 to 5 mg/hr to allow a total infusion time of no less than 1.5 hours.
4. Observe patient for 60 minutes following infusion (unless prescriber indicates this is not necessary).
5. Reschedule patient for next weekly infusion.

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
- ☐ diphenhydrAMINE (BENADRYL) capsule, 50 mg, oral, ONCE, every visit
- ☐ loratadine (CLARITIN) tablet, 10 mg, oral, ONCE, every visit
  (Choose as alternative to diphenhydrAMINE if needed)

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MEDICATIONS:

Agalsidase beta (FABRAZYME) 1 mg/kg = _____ mg in sodium chloride 0.9% IV infusion, ONCE, every 2 weeks x _____ doses *(Pharmacist will round dose to nearest 5 mg vial and modify during order verification)*

Administer using an in-line low protein binding 0.2 micron filter. Initial infusion: Rate should not exceed 15 mg/hr. Subsequent infusions if no infusion reactions: rate may be increased in increments of 3 to 5 mg/hr to allow a total infusion time of no less than 1.5 hours. Total volume will be between 50-500 mL based on calculated dose:

≤ 35 mg	50 mL minimum total volume
35.1 – 70 mg	100 mL minimum total volume
70.1 – 100 mg	250 mL minimum total volume
> 100 mg	500 mL minimum total volume

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.

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

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

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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