ADULT AMBULATORY INFUSION ORDER

CHO: ALGLUCOSIDASE ALFA (LUMIZYME) INFUSION

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 PRESCRIBING:

☐ Send FACE SHEET and H&P or most recent chart note.

☐ 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
testation_form.pdf
knowledgement_form.pdf
pdf
   d. Provider or Healthcare professional administering drug MUST complete the Lumizyme
      Infusion Form and fax in to Gemzyme

☐ 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, ONCE, EVERY 2 WEEKS, until discontinued. 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, IV ONCE, EVERY 2 WEEKS, at
least 10 days apart, until discontinued. (pharmacist to round dose for vial size)
   Refer to nursing communication order for infusion instructions; refrigerate and protect from light; do
not infuse with other IV products
   - Administer without delay post-prep, using in-line low protein binding 0.2 micrometer filter
   - 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
ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

☐ Alglucosidase alfa (LUMIZYME) _____ mg/kg in NaCl 0.9% 500 mL, IV ONCE, EVERY 2 WEEKS, at least 10 days apart, for _________ number of doses (pharmacist to round dose for vial size)
  Refer to nursing communication order for infusion instructions; refrigerate and protect from light; do not infuse with other IV products
  - Administer without delay post-prep, using in-line low protein binding 0.2 micrometer filter
  - 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

☐ NaCl 0.9% IV bolus 50 mL, IV ONCE, EVERY 2 WEEKS, at least 10 days apart, until discontinued. Flush following infusion. Administer using the final infusion rate.

NURSING ORDERS:
1. Nursing Communication, EVERY 2 WEEKS, at least 10 days apart, until discontinued. Infusion Line Preparation: Prime the infusion line with the infusion solution via gravity to minimize bubbles within the infusion line. Alglucosidase alpha (LUMIZYME) should NOT be infused in the same line with other products.
2. Nursing Communication, EVERY 2 WEEKS, at least 10 days apart, until discontinued. Contact IV therapy to start IV. Prepare for infusion by warming patient with warm blankets and hand warmers for 10 minutes.
3. Nursing Communication, EVERY 2 WEEKS, at least 10 days apart, until discontinued. Alglucosidase alpha (LUMIZYME) 20mg/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. Nursing Communication, EVERY 2 WEEKS, at least 10 days apart, until discontinued. 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 minutes - If no signs of IARs, go to next step
   Step 2: 3 mg/kg/hr (___ mL/hr) administered over 30 minutes - If no signs of IARs, go to next step
   Step 3: 5 mg/kg/hr (___ mL/hr) administered over 30 minutes - If no signs of IARs, go to next step
   Step 4: 7 mg/kg/hr (___ mL/hr) administered over 30 minutes - If no signs of IARs, complete infusion at this rate
5. Vital Signs, EVERY 2 WEEKS, at least 10 days apart, until discontinued. Routine.
   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
6. Nursing communication order, every visit: Manage line per OHSU Vascular Access Flushing Procedure # HC-NSG-236-PRO (Could include flushes with D5W, NS, heparin 10 units/mL, heparin units/mL, or t-PA 2 mg/2mL)
7. Nursing communication order, every visit: Manage central venous catheter per OHSU De-clotting Procedure for Vascular Access Policy # HC-NSG-126-POL
8. Nursing communication order, every visit: Manage site access per OHSU PICC and Central Venous Access Site Assessment and Dressing Changes Policy # HC-NSG-189-POL
HYPERSENSITIVITY MEDICATIONS:
1. DiphenhydRAMINE 25 mg IV, AS NEEDED x2 doses (Max dose: 50 mg) for hypersensitivity reaction
2. EPINEPHrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
3. Hydrocortisone 100 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. Nursing communication order, every visit: Please follow treatment algorithm for acute infusion reaction. Algorithm is located in the OHSU Policy Management System.

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

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.

OLC Central Intake Nurse:
Ph: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient’s preferred clinic location:
INFUSION CLINIC LOCATIONS

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

- **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

- **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

Provider signature: ___________________________  Date/Time: ________________

Printed Name: ___________________________  Phone: ________________  Fax: ________________

Infusion orders located at: [www.ohsuknight.com/infusionorders](http://www.ohsuknight.com/infusionorders)