St. Charles HEALTH SYSTEM	**St. Charles Health System** Adult Ambulatory Infusion Order Alglucosidase alfa (LUMIZYME)	Patient Name: Date of Birth: *Patient Identification*

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

Treatment Start Date: _____ Allergies: _____
Weight: _____kg Height: _____ cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety
1. FACE SHEET with complete INSURANCE information and patient CONTACT information
2. Recent VISIT NOTE to support treatment (if not available in Epic)
3. LAB RESULTS for any required prescreening (if not available in Epic)
4. DIAGNOSIS CODE _____
5. Patient NAME and DATE OF BIRTH on EVERY page faxed

GUIDELINES FOR ORDERING

1. 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.

PRE-SCREENING LABS: (Results must be available prior to initiation of therapy):
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 x4
☐ IgG antibody ONCE annually
☐ 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. For mild to moderate infusion reactions, decrease rate or temporarily hold; for severe hypersensitivity reactions or anaphylaxis, discontinue immediately and initiate appropriate medical treatment.

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.
- Protect from light; do not infuse with other IV products.

INFUSION MONITORING/REACTION:

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebule, AS NEEDED x1 dose for hypersensitivity reaction

☐ Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

_____

Patient will be treated at the following infusion location:

☑ St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

St. Charles HEALTH SYSTEM	**St. Charles Health System** Adult Ambulatory Infusion Order Alglucosidase alfa (LUMIZYME)	Patient Name: Date of Birth: *Patient Identification*
ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE		

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ License #: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

Plan will expire 1 year after signature date at which time a new order will need to be placed