

**ORDERING OFFICE, ALSO FAX:**

- Most recent labs
- Supporting clinicals / Recent H&P
- Insurance card, front and back

# Alglucosidase alfa (Lumizyme)

Provider Order Form



Date:	Patient Name:	DOB:
ICD-10 code (required):		
ICD-10 description:		
<input type="checkbox"/> NKDA Allergies:		Weight lbs/kg:
Ordering Provider:	Provider NPI:	
Referring Practice Name:	Phone:	Fax:
Practice Address:	City:	State: Zip Code:
<b>NURSING</b>		
<input checked="" type="checkbox"/> Provide nursing care per IVX Standard Nursing Procedures, including reaction management		
<b>LABORATORY ORDERS</b>		
<input type="checkbox"/> CBC	<input type="checkbox"/> every other dose	<input type="checkbox"/> every _____
<input type="checkbox"/> CMP	<input type="checkbox"/> every other dose	<input type="checkbox"/> every _____
<input type="checkbox"/> CRP	<input type="checkbox"/> every other dose	<input type="checkbox"/> every _____
<input type="checkbox"/> Other:		
<b>PRE-MEDICATION ORDERS (ADMINISTER 30 MINUTES PRIOR TO PROCEDURE)</b>		
<input type="checkbox"/> acetaminophen (Tylenol) <input type="checkbox"/> 500mg / <input type="checkbox"/> 650mg / <input type="checkbox"/> 1000mg PO		
<input type="checkbox"/> cetirizine (Zyrtec) 10mg PO		
<input type="checkbox"/> loratadine (Claritin) 10mg PO		
<input type="checkbox"/> diphenhydramine (Benadryl) <input type="checkbox"/> 25mg / <input type="checkbox"/> 50mg <input type="checkbox"/> PO / <input type="checkbox"/> IV		
<input type="checkbox"/> methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg / <input type="checkbox"/> 125mg IV		
<input type="checkbox"/> Other:		
Dose:	Route:	Frequency:
<b>INFUSION THERAPY</b>		
<input checked="" type="checkbox"/> alglucosidase alfa (Lumizyme) in 0.9% sodium chloride, intravenous infusion, final concentration of 0.5 to 4mg/ml, administer with 0.2 micron filter		
▪ <input type="checkbox"/> 20mg/kg / <input type="checkbox"/> other _____		
▪ Frequency: <input type="checkbox"/> every 2 weeks		
▪ Administer over approximately 4 hours, in a step wise manner. Initial infusion rate should be no more than 1mg/kg/hr. Infusion rate may be increased by 2mg/kg/hr every 30 minutes after patient tolerance is established. Max rate is 7mg/kg/hr. If the patient is stable, alglucosidase alfa may be administered at the maximum rate of 7mg/kg/hr until the infusion is completed.		
<input checked="" type="checkbox"/> Flush with 0.9% sodium chloride at the completion of infusion		
<input type="checkbox"/> Patient is required to stay for 30-minute observation post infusion		
<input type="checkbox"/> Patient is NOT required to stay for observation time		
<input type="checkbox"/> Refills: <input type="checkbox"/> Zero / <input type="checkbox"/> for 12 months / <input type="checkbox"/> _____ (if not indicated order will expire one year from date signed)		
<b>GENERAL PLAN COMMUNICATION</b>		
Special instructions/notes:		

**Ordering Provider: Initial here \_\_\_\_\_ and proceed to the next page.**

**ADULT REACTION MANAGEMENT**

- Observe for **hypersensitivity reaction:** Fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation
- If reaction occurs:
  - Stop infusion
  - Maintain/establish vascular access
  - Notify referring provider
  - Consider giving the following PRN
    1. Acetaminophen (Tylenol) 650mg PO **OR** \_\_\_\_\_mg for pain or fever > 38 C/100.4 F
    2. Diphenhydramine (Benadryl) 25-50mg in 10ml NS slow IV push for rash, itching, pruritis
    3. Ranitidine 25mg in 10ml NS slow IV push over 5 minutes (Consider if patient already given IV Benadryl)
    4. Ondansetron (Zofran) 4mg Slow IV push over 5 minutes for nausea or vomiting.
    5. Methylprednisolone (Solumedrol) 125mg **OR** \_\_\_\_\_mg slow IV push.
    6. Other \_\_\_\_\_
  - When symptoms resolve resume infusion at 50% previous rate and increase per manufacturer's guidelines
- Severe allergic/anaphylactic reaction:**
  - If symptoms are rapidly progressing or continuing after administration of prn medications above and signs symptoms of severe allergic/anaphylactic reaction (angioedema, swelling of the mouth, tongue, lips, or airway, dyspnea, bronchospasm with or without hypotension or hypertension.)
    1. Call 911
    2. Consider giving epinephrine (1:1000 strength) 0.3ml IM. May repeat every 5-15 minutes to a maximum of 3 doses.
    3. Treat hypotension with 500ml 0.9% sodium chloride bolus. Repeat as needed to maintain systolic BP >90.
    4. Have oxygen by nasal canula available and administer 2-15 liters, titrate to keep Spo2 >92%
    5. Have Automated External Defibrillator available
    6. Notify referring provider. If unable to reach referring provider, notify Local Medical Director.
    7. Discontinue treatment

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**Patient Date of Birth**

\_\_\_\_\_  
**Provider Name (Print)**

\_\_\_\_\_  
**Provider Signature**

\_\_\_\_\_  
**Date**

**Designate the desired location and fax the order form to:**

**CALIFORNIA fax: (844) 889-0275** | \_\_\_San Mateo \_\_\_Fremont \_\_\_San Ramon \_\_\_TBD

**ILLINOIS fax: (312) 253-7244** | \_\_\_Glenview \_\_\_Schaumburg \_\_\_TBD

**KANSAS / MISSOURI fax: (844) 900-1292** | \_\_\_Overland Park, KS \_\_\_Lee's Summit, MO \_\_\_Briarcliff, MO \_\_\_TBD

**OHIO fax: (844) 627-2675** | \_\_\_Dublin \_\_\_Pickerington \_\_\_TBD

**PENNSYLVANIA fax: (844) 820-9641** | \_\_\_Malvern \_\_\_Bensalem \_\_\_Montgomeryville \_\_\_East Shore \_\_\_West Shore \_\_\_TBD

**TENNESSEE fax: (844) 627-2518** | \_\_\_Brentwood \_\_\_Hendersonville \_\_\_TBD

