Spectrum Health Helen DeVos children's hospital

Physician's Orders ALGLUCOSIDASA ALFA (LUMIZYME) - PEDIATRIC, OUTPATIENT, INFUSION CENTER

Patient Name
DOB
MRN
Physician
FIN

Defaults for orders not otherwise specified below:
- ☐ Interval: Every 14 days

Duration:
- ☐ Until date: _____
- ☐ 1 year
- ☐ _____# of Treatments

Anticipated Infusion Date_____ ICD 10 Code with Description_____

Height_____(cm) Weight_____(kg) Allergies_____

Provider Specialty

☐ Allergy/Immunology	☐ Infectious Disease	☐ OB/GYN	☐ Rheumatology
☐ Cardiology	☐ Internal Med/Family Practice	☐ Other	☐ Surgery
☐ Gastroenterology	☐ Nephrology	☐ Otolaryngology	☐ Urology
☐ Genetics	☐ Neurology	☐ Pulmonary	☐ Wound Care

Site of Service

☐ SH Gerber	☐ SH Lemmen Holton (GR)	☐ SH Pennock	☐ SH United Memorial
☐ SH Helen DeVos (GR)	☐ SH Ludington	☐ SH Reed City	☐ SH Zeeland

Appointment Requests

☑ Infusion Appointment Request
Status: Future, Expected: S, Expires: S+366, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Infusion

Provider Reminder

	Interval	Duration
☑ ONC PROVIDER REMINDER	Once	1 treatment

Premedication is not required, but can be considered for the prevention of subsequent infusion reactions. For symptoms of allergic reaction or anaphylaxis, order "Peds Hypersensitivity Reactions Therapy Plan".

Pre-Medications

☐ **Acetaminophen Premed-select Susp,tab Or Chewable.**

☐ acetaminophen (TYLENOL) 32 MG/ML suspension 10 mg/kg (Treatment Plan)
10 mg/kg, Oral, Once, For 1 Doses
Give 30 to 60 minutes prior to infusion.
Recommended maximum single dose is 1000mg
No more than 5 doses from all sources in 24 hour period, not to exceed 4000mg/day

☐ acetaminophen (TYLENOL) tablet 10 mg/kg (Treatment Plan)
10 mg/kg, Oral, Once, Starting S, For 1 Doses
Give 30 to 60 minutes prior to infusion.
Recommended maximum single dose is 1000mg
No more than 5 doses from all sources in 24 hour period, not to exceed 4000mg/day

☐ acetaminophen (TYLENOL) dispersable / chewable tablet 10 mg/kg (Treatment Plan)
10 mg/kg, Oral, Once, Starting S, For 1 Doses
Give 30 to 60 minutes prior to infusion.
Recommended maximum single dose is 1000mg
No more than 5 doses from all sources in 24 hour period, not to exceed 4000mg/day

☐ **Diphenhydramine Premed-select Cap,liquid Or Injection.**

☐ diphenhydrAMINE (BENADRYL) capsule 0.5 mg/kg (Treatment Plan)
0.5 mg/kg, Oral, Once, Starting S, For 1 Doses
Give 30 to 60 minutes prior to infusion.
Recommended maximum single dose is 50mg

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NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.

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ALGLUCOSIDASA ALFA (LUMIZYME) - PEDIATRIC, OUTPATIENT, INFUSION CENTER *(CONTINUED)*

Patient Name

DOB

MRN

Physician

FIN

Pre-Medications (continued)

☐ diphenhydrAMINE (BENADRYL) 12.5 MG/5ML elixir 0.5 mg/kg (Treatment Plan)
0.5 mg/kg, Oral, Once, Starting S, For 1 Doses
Give 30 to 60 minutes prior to infusion.
Recommended maximum single dose is 50mg

☐ diphenhydrAMINE (BENADRYL) injection 0.5 mg/kg (Treatment Plan)
0.5 mg/kg, Intravenous, Once, Starting S, For 1 Doses
Give 30 to 60 minutes prior to infusion.
Recommended maximum single dose is 50mg

☐ methylPREDNISolone sodium succinate (SOLU-Medrol) injection 0.5 mg/kg (Treatment Plan)
0.5 mg/kg, Intravenous, for 15 Minutes, Once, For 1 Doses
Administer 30 to 60 minutes prior to infusion.
Recommended maximum single dose is 80mg

☐ Pre-medications with dose: _____

☐ Pre-medications with dose: _____

Medications

☑ alglucosidase alfa (LUMIZYME) 20 mg/kg in sodium chloride 0.9 % IVPB
20 mg/kg, Intravenous, Titrate, Starting S
Infuse through a low protein-binding, 0.2 micron in-line filter. Do not administer products with visualized particulate matter. Infuse over ~4 hours; initiate at _____ mL/hr [0.25 mL/kg/hr; 1 mg/kg/hour]. If tolerated, increase by _____ mL/hr [0.5 mL/kg/hr; 2 mg/kg/hour] every 30 minutes to a maximum rate of _____ mL/hr [1.75 mL/kg/hr; 7 mg/kg/hour]. Decrease rate or temporarily hold for infusion reactions. Monitor vital signs prior to each rate increase. Protect from light.

Nursing Orders

☑ ONC NURSING COMMUNICATION 1
- Place intermittent infusion device as necessary.

- Infuse through a 0.2 micron, low protein binding inline filter.

- Do not administer if the solution is discolored or if foreign particulate matter is present.

- Monitor vital signs with Pulse oximetry, Obtain heart rate, respiratory rate, blood pressure and pulse oximetry and assess for symptoms of anaphylaxis every 15 minutes through 30 minutes after drug completion.

- Notify attending physician, NP or PA-C and stop drug infusion immediately if patient has itching, hives, swelling, fever, rigors, dyspnea, cough or bronchospasm. Notify if greater than 20% decrease in systolic or diastolic blood pressure.

- At the end of infusion, flush secondary line with 0.9% Sodium Chloride.

- Verify that patient has diphenhydramine / Epi-pen available (as appropriate) for immediate home use. Advise patient that severe hypersensitivity or anaphylactic reactions may occur during and after infusion. Inform patients of signs and symptoms of anaphylaxis and hypersensitivity reactions, and importance of seeking medical care.

☑ ONC NURSING COMMUNICATION 2
- Observe patient in the infusion center for 30 minutes following completion of infusion.

Telephone order/Verbal order documented and read-back completed. Practitioner's initials _____

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

TRANSCRIBED: TIME	DATE	VALIDATED: TIME	DATE	ORDERED: TIME	DATE	Pager #
	Sign		R.N. Sign		Physician Print	Physician