Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO9031

ADULT AMBULATORY INFUSION ORDER

Idursulfase (ELAPRASE) Infusion

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

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. **Send FACE SHEET and H&P or most recent chart note.**
2. Life-threatening anaphylactic reactions have occurred in some patients during and up to 24 hours after idursulfase infusions.
3. Patients with compromised respiratory function or acute respiratory disease may be at risk of serious acute exacerbation of their respiratory compromise due to hypersensitivity reactions and require additional monitoring.
4. Development of anti-idursulfase IgG antibodies has been reported in 51% of patients; may increase incidence of hypersensitivity reactions.
5. Use with caution in patients at risk for fluid overload or in conditions where fluid restriction is indicated (eg, acute underlying respiratory illness, compromised cardiac and/or respiratory function); conditions may be exacerbated during infusion.
6. Patients and healthcare providers are encouraged to participate in the Hunter Outcome Survey, intended to monitor disease progression, patient outcomes, and long-term effects of therapy. For more information, refer to www.elaprase.com or call OnePath℠ at 1-866-888-0660.

NURSING ORDERS:

1. NURSING COMMUNICATION #1 – Infuse at an initial rate of 8 mL/hour for the first 15 minutes. If tolerated, may increase rate by 8 mL/hour increments every 15 minutes (Maximum rate: 100 mL/hr).
2. VITAL SIGNS – Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion as well as upon completion.

MEDICATIONS:

- PROVIDER TO PHARMACIST COMMUNICATION – Pharmacist will round dose to nearest 6 mg vial and modify during order verification.
- Idursulfase (ELAPRASE) 0.5 mg/kg in sodium chloride 0.9%, intravenous, ONCE, 1 time a week

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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 (Policy HC-PAT-133-GUD). 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 reaction.
3. EPINEPHrine HCl (ADRENALIN) injection, 0.5 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity reaction.
4. Hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction. Dilute vial by either pressing chamber for Act-O-Vial or diluting powder vial with 2 mL SWFI or NS for injection.
5. Famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose, for hypersensitivity reaction.

STAFF DIRECTIVES (as applicable):

1. Infusion staff to follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
2. Pharmacist to select appropriate admixture options including (as applicable) formulation, fluid base type, volume, concentration, administer-over time, and rate according to the package insert, drug information references, and facility policies, procedures, and practice standards.
3. Biosimilar substitutions may be permitted by infusion site policies or Collaborative Drug Therapy Management (CDTM) agreements. A pharmacist may substitute the biosimilar for authorized reasons, which may include infusion site preference or insurance reimbursement requirement. If it is NOT acceptable to substitute per site preference or insurance, check to Dispense as Written (DAW) ☐ and note the REQUIRED biosimilar: _____
4. Pharmacist may select or update orders to the site's preferred biosimilar. In addition, if insurance requires a specific biosimilar agent for reimbursement, pharmacy may update the order at sites with a Collaborative Drug Therapy Management agreement (CDTM). If it is NOT acceptable to substitute per site preference or insurance, check to Dispense as Written (DAW) ☐ and note the REQUIRED biosimilar: _____

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

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☑ **Please indicate the patient's preferred clinic location below**

☐	**HILLSBORO MEDICAL CENTER** 364 SE 8th Ave, Medical Plaza Suite 108B, Hillsboro, OR 97123	Phone (503) 681-4124 Fax (503) 681-4120
☐	**ADVENTIST HEALTH – PORTLAND** Infusion Services, 10123 SE Market St, Portland, OR 97216	Phone (503) 261-6631 Fax (503) 261-6756
☐	**ADVENTIST HEALTH – COLUMBIA GORGE** **Celilo Cancer Center, 1800 E 19th St, The Dalles, OR 97058**	Phone **(541) 296-7585** Fax **(541) 296-7610**