



Patient Name: _____

Date of Birth: _____

 PHYO
 CMC85776-001NS Rev. 7/2021

**Laronidase (ALDURAZYME)
 Infusion Therapy Plan**
Baseline Patient Demographic

To be completed by the ordering provider.

 Diagnosis: _____ Height: _____ cm Weight: _____ kg Body Surface Area: _____ (m²)

 NKDA - No Known Drug Allergies Allergies: _____

Therapy Plan orders extend over time (several visits) including recurring treatment.

Please specify the following regarding the entire course of therapy:

Duration of treatment: _____ weeks _____ months _____ unknown

 Treatment should begin: as soon as possible (within a week) within the month

****Plans must be reviewed / re-ordered at least annually. ****
ORDERS TO BE COMPLETED FOR EACH THERAPY
ADMIT ORDERS
 Height and weight

 Vital signs

Hypotension Defined Admit
 Nursing communication

Prior to starting infusion, please determine the patient's threshold for hypotension as defined by the following parameters. This information will be needed in the event of an infusion reaction occurring.

Hypotension is defined as follows:

1 month to 1 year - systolic blood pressure (SBP) less than 70

1 year to 11 years - systolic blood pressure (SBP) less than 70 + (2 x age in years)

11 years to 17 years - systolic blood pressure (SBP) less than 90

OR any age - systolic blood pressure (SBP) drop of more than 30% from baseline.

Baseline systolic blood pressure (SBP) x 0.7 = value below defined as hypotension.

NURSING ORDERS

Please select all appropriate therapy

IV START NURSING ORDERS
 Insert peripheral IV / Access IVAD

Place PIV if needed or access IVAD if available

 lidocaine 1% BUFFERED (J-TIP LIDOCAINE)

0.2 mL, INTRADERMAL, PRN

 when immediate procedure needed when procedure will take about 1 minute patient / family preference for procedure

 Administration Instructions: NOTE: Do not use this medication in patients with bleeding disorders, platelets \leq 20,000, or in patients taking anticoagulants, when accessing implanted ports or using a vein that will be utilized for chemotherapy administration, nor for pre-term infants or neonates.

 lidocaine - prilocaine (EMLA) cream

TOPICAL, PRN

 when more than 60 minutes are available before procedure when procedure will take more than 1 hour

 patient / family preference for procedure

Administration Instructions: NOTE: In children < 3 months of age, or < 5 kg in weight, maximum application time is 1 hour.

 lidocaine - tetracaine (SYNERA) patch

TOPICAL, PRN

 when 20 - 30 minutes are available before procedure when procedure will take more than 1 hour

 when anticipated pain is less than 5 mm from skin surface patient / family preference for procedure



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ORDERS TO BE COMPLETED FOR EACH THERAPY

NURSING ORDERS

 lidocaine with transparent dressing 4% kit

TOPICAL, PRN

 when 20 - 30 minutes are available before procedure when procedure will take more than 1 hour patient / family preference for procedure Heparin flush**heparin flush**

10 - 50 units, INTRAVENOUS, PRN, IV line flush. Per protocol, heparin should not be used to flush peripheral IVs. This heparin flush should be used with all central lines including IVADs, with the exception of de-accessing the IVAD.

heparin flush

100 - 300 units, INTRAVENOUS, PRN, IV line flush. Per protocol, heparin should not be used to flush peripheral IVs. For use only when de-accessing IVADs.

 Sodium chloride flush**Sodium chloride flush 0.9% injection**

1 - 20 mL, INTRAVENOUS, PRN, IV line flush

Sodium chloride - preservative free 0.9% injection

1 - 30 mL, INTRAVENOUS, PRN, IV line flush

PRE-MEDICATIONS

 Acetaminophen pre-medication 60 minutes prior (15 mg / kg, maximum 650 mg)**Nursing communication**

Administer only one of the acetaminophen orders, suspension or tablets, do not give both.

acetaminophen suspension

15 mg / kg, ORAL, for 1 dose pre-medication, give 60 minutes prior to infusion

Dose: _____**acetaminophen tablet**

15 mg / kg ORAL, for 1 dose pre-medication, give 60 minutes prior to infusion

Dose: _____ Ibuprofen pre-medication 60 minutes prior (10 mg / kg, maximum 600 mg)**nursing communication**

Administer only one of the ibuprofen orders, suspension or tablets, do not give both.

ibuprofen suspension

10 mg / kg, ORAL, for 1 dose pre-medication, give 60 minutes prior to infusion

Dose: _____**ibuprofen tablet**

10 mg / kg ORAL, for 1 dose pre-medication, give 60 minutes prior to infusion

Dose: _____ Diphenhydramine pre-medication 60 minutes prior (1 mg / kg, maximum 50 mg)**Nursing communication**

Administer only one of the diphenhydrAMINE pre-medication orders, liquid, capsule or injection, do not give more than one of the orders as a pre-medication.

diphenhydrAMINE liquid

1 mg / kg, ORAL, for 1 dose pre-medication, give 60 minutes prior to infusion

Dose: _____**diphenhydrAMINE capsule**

1 mg / kg ORAL, for 1 dose pre-medication, give 60 minutes prior to infusion

Dose: _____**diphenhydrAMINE injection**

1 mg / kg, INTRAVENOUS, 1 dose pre-medication, give 60 minutes prior to infusion

Dose: _____



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INTRA - PROCEDURE

 Nursing communication

DO NOT SHAKE. Administer with PVC infusion set equipped with low protein binding 0.2 micron filter.

 Vital signs

Observe for hypoxia, changes in blood pressure, respiratory distress, angioedema and seizures during infusion. If severe reaction occurs, immediately suspend the infusion and contact ordering provider.

 Nursing communication

Administer through port at following schedule:

	Rate	Time at that rate
Initial Infusion Rate	5 mL / hour	for 15 minutes
If tolerated, increase rate to	10 mL / hour	for 15 minutes
If tolerated, increase rate to	20 mL / hour	for 15 minutes
If tolerated, increase rate to	40 mL / hour	for 15 minutes
If tolerated, increase rate to	80 mL / hour	until entire bag is infused
Maximum Rate = 80 mL / hour		Infusion complete

 Physician communication order

Dose of laronidase (ALDURAZYME) = 0.58 mg / kg. Vials come as 2.9 mg / 5 mL. For patients < 20 kg, select the 100 mL volume option for the sodium chloride 0.9% fluid. For patients ≥ 20 kg select the 250 mL volume option for the sodium chloride 0.9% fluid. Please enter the dose of laronidase in 'mg' to facilitate prior authorization requirements.

 laronidase in sodium chloride 0.9% infusion

INTRAVENOUS, ONCE, 1 hour after treatment start time

DO NOT SHAKE. Administer the diluted laronidase with PVC infusion set equipped with low protein binding 0.2 micron filter.

Dose: _____ Sodium Chloride 0.9% diluent: 100 mL 250 mL

Administer through port at following schedule:

	Rate	Time at that rate
Initial Infusion Rate	5 mL / hour	for 15 minutes
If tolerated, increase rate to	10 mL / hour	for 15 minutes
If tolerated, increase rate to	20 mL / hour	for 15 minutes
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If tolerated, increase rate to	80 mL / hour	until entire bag is infused
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 Therapy Appointment Request

Please select department for the therapy appointment request:

Expires in 365 days

 Dallas Special Procedures Plano Infusion Center Dallas Allergy Dallas Transplant Dallas Neurology

EMERGENCY MEDICATIONS

 Nursing communicationHives or cutaneous reaction only – no other system involvement **PATIENT IS HAVING A DRUG REACTION:**

- Stop the infusion
- Give diphenhydramine as ordered
- Check vitals including blood pressure every 5 minutes until further orders from provider.
- Connect patient to monitor (cardiac / apnea, blood pressure and oxygen saturation), if not already on one
- Notify provider for further orders



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EMERGENCY MEDICATIONS

2. Hives or cutaneous reaction plus one other system, i.e. abdominal cramping, vomiting, hypotension, altered mental status, respiratory distress, mouth / tongue swelling **PATIENT IS HAVING ANAPHYLAXIS:**

- a. Stop the infusion
- b. Call code – do not wait to give epinephrine
- c. Give epinephrine as ordered
- d. Notify provider
- e. Check vitals including blood pressure every 5 minutes until the code team arrives.
- f. Connect patient to monitor (cardiac / apnea, blood pressure and oxygen saturation), if not already on one.
- g. Give diphenhydramine once as needed for hives
- h. May repeat epinephrine every 5 minutes x 2 doses for persistent hypotension and respiratory distress with desaturation until code team arrives.
- i. May give albuterol as ordered for wheezing with oxygen saturations stable while waiting for code team, continue to monitor oxygen saturation.

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 OR any age – systolic blood pressure (SPB) drop more than 30% from baseline.
 Baseline systolic blood pressure x 0.7 = value below defined as hypotension.

EPINEPHrine Injection Orderable For Therapy Plan
(AMPULE / EPI - PEN JR. / EPI - PEN) 0.01 mg / kg

0.01 mg / kg, INTRAMUSCULAR, EVERY 5 MINUTES PRN, for anaphylaxis and may be repeated for persistent hypotension and respiratory distress with desaturation until the code team arrives, for 3 doses

Use caution with PIV administration. This solution has a pH < 5, or a pH > 9, or an osmolality > 600 mOsm / L.

Dose: _____

Cardio / Respiratory Monitoring
Rationale for Monitoring: High risk patient (please specify risk)

- Clinically significant cardiac anomalies or dysrhythmias
- Recent acute life-threatening event
- Unexplained or acutely abnormal vital signs
- Artificial airway (stent, tracheostomy, oral airway)
- Acute, fluctuating or consistent oxygen requirements

Monitor Parameters (select all that apply): Heart rate Oxygen saturation Respiratory rate

Telemetry Required: Yes No

diphenhydrAMINE injection

1 mg / kg, INTRAVENOUS, ONCE PRN, for hives or cutaneous reaction, for 1 dose maximum dose = 50 mg per dose, 300 mg per day.

Dose: _____

Albuterol for aerosol

0.25 mg / kg., INHALATION ONCE PRN, for wheezing, but oxygen saturations stable while waiting for code team, continue to monitor oxygen saturation for 1 dose

Dose: _____

POST - PROCEDURE

Nursing communication

Flush PIV or IVAD with 20 mL 0.9% sodium chloride (250 mL bag) at the completion of the infusion.
 Flush IVAD with saline and heparin flush per protocol prior to de-accessing IVAD.
 Discontinue PIV prior to discharge.

sodium chloride flush 0.9%

0 - 25 mL / hour, INTRAVENOUS, PRN, IV line flush

Dose: _____

(circle one):
 MD DO

Signature of Provider

Credentials

Date

Time

Printed Name of Provider



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Dose: _____

(circle one):
MD DO

Signature of Provider

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Date

Time

Printed Name of Provider