Orsini
Rare Disease Pharmacy Solutions

Fax To: 847.427.7976 **Phone:** 800.240.9572

LAMZEDE® INFUSION ORDER

(velmanase alfa-tycv)

1 PATIENT INFORMATION

Patient Name: ____________________ DOB: __________

Primary Phone: ____________________ Gender: Male Female

Address: ____________________

City, State, Zip: ____________________

Allergy: ____________________

Patient Weight: _____ Lbs _____ Kg Date Weighed: __________

Venous Access Device: Peripheral IV Port ____G ____ Inch needle
PIV for port access complications

2 PRESCRIBER INFORMATION

Prescriber's Name: ____________________

Contact Person: ____________________ Phone: __________

NPI #: ____________________

Address: ____________________

Address: ____________________

City, State, Zip: ____________________

Phone: __________ Fax: __________

ICD-10 Diagnosis: *E77.1 (Defects in glycoprotein degradation) - Alpha-mannosidosis*

3 CATHETER ACCESS AND FLUSH PROTOCOL

ACCESS TYPE	CATHETER FLUSH ORDERS	
Peripheral PORT *(Also include Peripheral IV for Port Malfunction)*	☒ **0.9% Saline Flush:** **Dispense:** 30 Days **Refills:** x 1yr OR ___ Refills Flush line/port with 10mL for patency/SASH protocol. **Heparin Flush:** **Dispense:** 30 Days **Refills:** x 1yr OR ___ Refills Flush port with _____ mL of Heparin _____ units/mL per SASH protocol.	**CathFlo:** 2 mg/2 mL as directed. *Pharmacy authorized to dispense upon home health nurse validated port occlusion.* ☐ **Dispense:** 1 Kit **Refills:** x 1yr OR ___ Refills

4 PRE-MEDICATION

Premedication for administration 30-60 min. prior to drug infusion:

- ☐ Antiemetic: ____________________ q.s. 1 month **Refill:** x 1yr OR ___ Refills ☐ Not Needed
- ☐ Antihistamine: ____________________ q.s. 1 month **Refill:** x 1yr OR ___ Refills ☐ Not Needed
- ☐ Corticosteroid: ____________________ q.s. 1 month **Refill:** x 1yr OR ___ Refills ☐ Not Needed
- ☐ LMX 4 or (EMLA) Lidocaine 2.5%/Prilocaine 2.5% cream - Apply topically 1 hour prior to starting IV or accessing port **QTY:** 1 **Refill**: x 1yr OR ___ Refills
- ☐ ____________________

5 TREATMENT REGIMEN

LAMZEDE DOSE	PRESCRIPTION
☒ 1mg/kg	Lamzede _____ mg IV every week _____ vials/infusion Disp: 28 days Refills: 12 months *Round up to the next whole vial (each 10mg vial to be reconstituted with 5mL Sterile Water to yield a concentration of 10mg/5mL)*

PREPARATION AND ADMINISTRATION

Total Infusion Volume is determined by patient's actual body weight and total number of reconstituted vials

Infusion Rate: ☐ Infuse over 60 min (Patient weight < 50kg) ☐ Infuse at 25mL/hr (Patient weight ≥ 50kg) ☐ Other rate: ____________________

Infuse reconstituted Lamzede solution through in-line low protein-binding 0.2µ filter

SKILLED NURSING VISIT

☒ As needed for IV access, administration, and proper clinical monitoring	Administration procedures to be followed per pharmacy protocol

Post Infusion: Flush IV with 10 mL 0.9% Sodium Chloride Injection, USP at final rate of drug infusion

Vital Signs: At baseline and at every ____ minutes during infusion, at completion of post-infusion flush and 30 minutes after completion of post-infusion flush

☒ **Supplies:** Provide infusion pump if needed, IV Pole, back-up peripheral IV kit and all necessary infusion supplies.

ALSO SEE PAGE 2 (LAMZEDE INFUSION REACTION MANAGEMENT ORDERS)

6 PROVIDER SIGNATURE ("LAMZEDE Infusion Order")

X ____________________
Product Substitution Permitted Signature Date of Signature

X ____________________
Dispense as Written Signature Date of Signature

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INFUSION REACTION MANAGEMENT ORDERS

Patient Name: ______________________________ DOB: ______________

7 EMERGENCY MEDICATIONS - **#q.s. Refill:** x 1yr OR____ Refills

Diphenhydramine 50 mg/mL ___________ mg IV if Infusion Reaction

Epinephrine 2-Pak 0.3 mg injector IM once for severe brochospasm/anaphylaxis and call 911 (for patients weighing greater than or equal to 30kg)

Epinephrine 2-Pak 0.15 mg injector - IM once for severe brochospasm/anaphylaxis and call 911 (for patients weighing < 30kg)

Corticosteroid: ______________________________

0.9% Saline 250 mL - administer at 50 mL/hr once LAMZEDE infusion stops:

0.9% Saline ____mL - administer at ____mL/hr once LAMZEDE infusion stops:

Supplies: Provide infusion pump if needed, IV Pole, back-up peripheral IV kit and all necessary infusion supplies.

EXAMPLES OF COMPLEX THERAPY INFUSION REACTIONS

- Fever
- Chills/Rigors
- Headache
- Rash/Itching
- Swelling/Edema
- Nausea/Vomiting
- Abdominal Pain
- Irritability
- Hypotension
- Dyspnea
- Respiratory Distress

INSTRUCTIONS DURING REACTION

1) STOP LAMZEDE and start 0.9% normal saline at 50 mL/hr.

Other Rate: _____mL/hr

2) ADMINISTER EMERGENCY MEDS FROM BOX 7 ACCORDING TO PHYSICAN ORDERS

☒ For severe anaphylaxis, administer appropriate Epinephrine Autoinjector IM - may repeat in 20 minutes if needed. Call 911.

3) CALL PHYSICIAN

8 PROVIDER SIGNATURE ("LAMZEDE Infusion Reaction Management Orders")

X ______________________________

Product Substitution Permitted Signature — Date of Signature

X ______________________________

Dispense as Written Signature — Date of Signature

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