IPILIMUMAB

Nursing Immune-Mediated Adverse Reaction Checklist

Patient name_____ **Date** _____

Ipilimumab is indicated for the treatment of unresectable or metastatic melanoma. Ipilimumab can result in severe and fatal immunemediated adverse reactions. The majority of immune-mediated reactions occurred during treatment; however, a few occurred weeks to months after discontinuation of ipilimumab. It is important to recognize and address symptoms early. This checklist is intended for use prior to dosing each patient and at any follow-up visits or calls with the patient to identify signs and symptoms associated with ipilimumab immune-mediated adverse reactions. This checklist is not meant to be all-inclusive.

- **ASK THE PATIENT ABOUT THE FOLLOWING SIGNS OR SYMPTOMS**
- **CALL THE PRESCRIBER BEFORE GIVING IPILIMUMAB IF THE PATIENT ANSWERS YES TO ANY OF THESE QUESTIONS**

GENERAL	Response		Notes
Are you unable to perform your normal activities?	Yes ❑	No ❑	
Are you having difficulty sleeping?	Yes ❑	No ❑	
Do you have a fever? Are you having headaches?	Yes ❑	No ❑	
Have you felt dizzy or light-headed?	Yes ❑	No ❑	
Have you noticed changes in your vision? If yes, how?	Yes ❑	No ❑	
Are you having problems with your eyes?	Yes ❑	No ❑	
Has your appetite changed? If yes, how?	Yes ❑	No ❑	
Have you had any changes in your libido?	Yes ❑	No ❑	
Are you having difficulty breathing?	Yes ❑	No ❑	
Have you started taking any new medications (prescription, nonprescription, or herbal)? If yes, which and when?	Yes ❑	No ❑	
GASTROINTESTINAL			
Are you nauseous and/or vomiting?	Yes ❑	No ❑	
How many bowel movements are you having each day?	Yes ❑	No ❑	
Is this different than normal? If yes, how?	Yes ❑	No ❑	
Are your stools loose or watery, or do they have a foul smell?	Yes ❑	No ❑	
Are you doing anything to manage it? If yes, what?	Yes ❑	No ❑	
Are you having painful bowel movements?	Yes ❑	No ❑	
Are you having cramping?	Yes ❑	No ❑	
Are you having pain in your belly? If yes, where?	Yes ❑	No ❑	
Have you seen blood or mucus in your stools?	Yes ❑	No ❑	
SKIN			
Does your skin itch?	Yes ❑	No ❑	
- If yes, is it keeping you up at night?	Yes ❑	No ❑	
Do you have a rash? If yes, where?	Yes ❑	No ❑	
- If yes, what are you using for it?	Yes ❑	No ❑	
Have you noticed that your skin is turning yellow?	Yes ❑	No ❑	
NEUROLOGIC			
Are you having weakness in your hands or legs?	Yes ❑	No ❑	
Are you having trouble gripping things?	Yes ❑	No ❑	
Have you noticed that you are dropping things?	Yes ❑	No ❑	
Are you having difficulty walking or are you unsteady?	Yes ❑	No ❑	
Are you having difficulty getting up from a chair?	Yes ❑	No ❑	
Are you having numbness or tingling in your hands or feet?	Yes ❑	No ❑	
Are you having trouble buttoning your shirt or pants?	Yes ❑	No ❑	
Are you having trouble picking things up?	Yes ❑	No ❑	