

## MHS Home/Alternate Site Infusion Services Ipilimumab (Yervoy) Infusion Order Set

ALL ORDERS MUST BE SIGNED AND DATED BY PRESCRIBING PROVIDER

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Weight:** \_\_\_\_\_ lb/kg

**Patient Phone Number:** (\_\_\_\_) \_\_\_\_-\_\_\_\_ **Requested Date of Service:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Patient Allergies:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **ICD – 10 Code:** \_\_\_\_\_

- Z45.2: Encounter for adjustment and management of vascular access device
- Z95.828: Presence of other vascular implants and grafts

**Baseline Labs (Required):**

- |                 |                      |               |
|-----------------|----------------------|---------------|
| • CBC/CMP       | Date: ____/____/____ | Result: _____ |
| • HBV screening | Date: ____/____/____ | Result: _____ |
| • HCV screening | Date: ____/____/____ | Result: _____ |
| • HIV screening | Date: ____/____/____ | Result: _____ |
| • TSH/Cortisol  | Date: ____/____/____ | Result: _____ |

**Lab Orders:** \_\_\_\_\_

**Additional Requirements:** In addition to order, please include H&P with documentation to support diagnosis. Must include ICD-10 Code(s) and supporting labs. **\*\* Emergency phone number for provider \_\_\_\_\_ (required) \*\***

### Provider Order for Ipilimumab (Yervoy) Infusion

ORDERS WITH CHECK  
BOXES

When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

**Biologic Infusion:**

Ipilimumab (Yervoy) added to 50-100 mL NS (final concentration between 1-2 mg/mL)

Weight: \_\_\_\_\_ kg

- Dose:  1 mg/kg every 3 weeks       1 mg/kg every 6 weeks       3 mg/kg every 3 weeks  
 10 mg/kg every 12 weeks       Other: \_\_\_\_\_

Infuse \_\_\_\_\_mg x \_\_\_\_\_ doses over 30 minutes (90 minutes for 10 mg/kg dose) via infusion pump with 0.22 micron in-line filter

**Additional Medications:**

- 0.9% NaCl (NS) PF flush in 10 mL syringe: Administer 5 – 30 mL IV as needed for establishing and maintaining IV access and for flushing IV line post infusion.
- Heparin: 100 units/mL for port OR 10 units/mL for other central line/midline, 3-5 mL PRN for de-accessing line.
- Cathflo (alteplase) 2 mg: Instill 2 mg (2 mL) into occluded catheter as needed for CVC/CVAD occlusion.
- Diphenhydramine 25 mg IV once, as needed for itching.
- Acetaminophen 325-650 mg tab/cap by mouth once, as needed for pain.

**Skilled Nurse Interventions:**

- Admit (first visit) patient to services for home infusion therapy of Ipilimumab (Yervoy).
- Complete Skilled Nurse visit with each infusion for ongoing home infusion therapy of Ipilimumab (Yervoy).
- Obtain vital signs (TPR & B/P) at baseline, with each infusion rate titration and at completion of infusion.
- Obtain patient weight at each visit.

CONTINUED ON NEXT PAGE

FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

**Patient Identification:**

Name:  
MRN:  
DOB:

Pre-printed order – Page 1 of 2  
Ipilimumab (Yervoy) Order Set  
MultiCare

**Skilled Nurse Interventions (continued):**

- Establish IV access and flush per policy to maintain patency.
- Draw labs as ordered.
- Add Ipilimumab (Yervoy) to 50-100 mL of Normal Saline 0.9%.
- Infuse Ipilimumab (Yervoy) as prescribed.
- Once infusion complete, flush IV line with Normal Saline 0.9% as prescribed.
- If vital signs are stable after infusion, Skilled Nurse will discontinue IV access and complete visit.

**If Hypersensitivity Reaction Develops (fever, chills, hypotension, rigors, itching, rash, etc.):**

The Skilled Nurse will:

- STOP THE INFUSION.
- Administer emergency medications as prescribed (below).
- For mild infusion reaction, may restart the infusion at a slower rate (verified with pharmacist) if symptoms resolve with medication.
- Contact Emergency Medical Services (EMS/911) if indicated.
- Increase vital sign monitoring to every 5 minutes.
- Contact provider via emergency phone number for additional instructions.
- Notify MHS Home/Alternate Site Infusion Pharmacist AND Nurse Supervisor.

**Emergency Medications:** To be administered by skilled nurse as needed for hypersensitivity reactions.

- **Diphenhydramine 50 mg/mL solution:** Inject **0.5 mL** (25 mg) into the vein via slow IV push over at least 2 minutes as needed for rash, itching, hives, flushing of skin, and/or mild-to-moderate hypersensitivity reaction. May give IM if no IV access is available. Max dose = 50 mg.
- **Methylprednisolone sodium succinate (SOLU-MEDROL) 125 mg/2 mL solution:** Inject **2 mL** (125 mg) into the vein as a slow IV push over at least 3 minutes once, as needed for hives, flushing of the skin, shortness of breath, chest tightness, tachycardia (HR>140 bpm), and/or moderate-to-severe hypersensitivity reaction. May give IM if no IV access is available.
- **EPINEPHrine (Adrenalin) 1 mg/mL solution:** Inject **0.3 mL** (0.3 mg) intramuscular every 5-15 minutes as needed (maximum 3 doses) for severe allergic reaction or anaphylaxis AND call 911 and provider.
- **Acetaminophen (Tylenol) 325 mg tab:** Take **2 tablets** (650 mg) by mouth as needed for fever (PRN for temperature > 101F/38.3C) and/or mild-to-moderate hypersensitivity reaction.
- **0.9% NaCl (NS) solution:** Infuse **500 mL** into the vein via gravity as needed at a rate needed to maintain IV access.
- **Oxygen:** Initiate oxygen by RN PRN chest pain or dyspnea to keep SpO2>90%. For 1-6 LPM, use NC. For 6-10 LPM, use simple mask.

**Code Status:** Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

**Was consent obtained:**  Yes  No (if yes, please send DOCUMENTATION of consent with order)

I certify that this patient is safe and appropriate to receive therapy from Home Infusion Services.

**Provider Signature:** \_\_\_\_\_ **Printed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**NPI:** \_\_\_\_\_ Orders expire in 12 months unless otherwise specified: \_\_\_\_\_

**Provider/Clinic Information:**

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_

**Return completed orders to:**

MultiCare Home/Alternate Site Infusion Services  
253-459-6650 (phone) / 253-864-2785 (fax)

FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

**Patient Identification:**

Name:  
MRN:  
DOB:

Pre-printed order – Page 2 of 2  
Ipilimumab (Yervoy) Order Set  
MultiCare

Revised 10/24