

Protocol Types

Infusion Treatment 1, Infusion Treatment 2, Infusion Treatment 3, Infusion Treatment 4

Patient name: _____ DOB: _____

Please include: ☐ Patient face sheet ☐ Insurance authorization (if other than Medicaid or non-Advantage Medicare)

Diagnosis: _____

Review: Every 358 days

Orders

	Interval	Defer Until	Duration
Provider Communication			
☒ Provider communication	Every 56 days		Until discontinued
Until discontinued Starting when released Until Specified			
Complete TB screening (PPD or QuantiFERON-TB Gold) prior to initiation of canakinumab. Patients with a positive TB screening result should be evaluated and treated as appropriate before starting therapy. Monitor for signs and symptoms of tuberculosis during and after treatment.			

Do not administer canakinumab during an active infection requiring medical intervention. Monitor for signs and symptoms of infection throughout treatment and notify the provider if a serious infection is suspected.

Supplemental Labs

☐ TB Screening Labs			
☐ QUANTIFERON TB GOLD	Every 365 days		Until discontinued
Status: Once, Expected: S, Clinic Collect, Blood, Venous, Blood, AH INTERNAL LAB (BEAKER), Routine			
☐ TB Skin Test	Every 365 days		Until discontinued
Routine, Once Starting when released, Miscellaneous			
Release to patient: Immediate			
Point Of Care			
☐ Read PPD	Every 365 days		Until discontinued
Routine, Once Starting when released, Miscellaneous			
Release to patient: Immediate			
Point Of Care			

Labs

☒ hCG, serum, qualitative	Every 56 days		Until discontinued
Status: Once, Expected: S, Clinic Collect, Blood, Venous, Blood, AH INTERNAL LAB (BEAKER), Routine			
Inclusion conditions: Patient could become pregnant			
☒ CBC and differential	Every 56 days		Until discontinued
Status: Once, Expected: S, Clinic Collect, Blood, Venous, Blood, AH INTERNAL LAB (BEAKER), Routine			
☒ Comprehensive metabolic panel	Every 56 days		Until discontinued
Status: Once, Expected: S, Clinic Collect, Blood, Venous, Blood, AH INTERNAL LAB (BEAKER), Routine			

Nursing Orders

	Interval	Defer Until	Duration
☒ Treatment conditions	Every 56 days		Until discontinued
Until discontinued Starting when released Until Specified			
Hold treatment and notify provider until TB screening has been completed and any positive TB screening result has been evaluated by the provider.			

Hold treatment and notify provider for active infection requiring medical intervention, fever, or signs/symptoms of serious infection.

Therapeutic Medications

☒ AH THERAPEUTIC MEDICATION CANAKINUMAB (ILARIS) SC INJECTION EVERY 8 WEEKS			
☐ canakinumab (Ilaris) injection 2 mg/kg (Treatment Plan)	Every 56 days		Until discontinued
2 mg/kg, subcutaneous, Once, Starting at treatment start time			
Do not shake. Do not inject into scar tissue.			
☐ canakinumab (Ilaris) injection 3 mg/kg (Treatment Plan)	Every 56 days		Until discontinued
3 mg/kg, subcutaneous, Once, Starting at treatment start time			
Do not shake. Do not inject into scar tissue.			
☐ canakinumab (Ilaris) injection 150 mg	Every 56 days		Until discontinued
150 mg, subcutaneous, Once, Starting at treatment start time			
Do not shake. Do not inject into scar tissue.			

Emergency Medications

☒ Nursing communication	PRN		Until discontinued
STAT, Until discontinued Starting when released Until Specified			
If hypersensitivity reaction occurs, stop infusion IMMEDIATELY and CALL provider.			
☒ Vital Signs	PRN		Until discontinued
STAT, Every 15 min Starting when released			
If a hypersensitivity reaction occurs, perform vital signs every 15 minutes for one hour, then every 30 minutes for 2 hours.			
☒ Nursing communication	PRN		Until discontinued
Once Starting when released			
If hypersensitivity reaction occurs:			
- Elevate head of bed 30 degrees and place patient's head at 30 degree angle if possible			
- Start 2 liters oxygen per nasal cannula and maintain airway			
- Change and maintain IV line with 1000 mL 0.9% Normal Saline			
☒ sodium chloride 0.9 % infusion	PRN		Until discontinued
30 mL/hr, intravenous, Continuous PRN, KVO, Starting when released, for 1 day			
☒ albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution 2.5 mg	PRN		Until discontinued
2.5 mg, nebulization, Every 4 hours PRN, Hypersensitivity reaction, Starting when released, for 1 day			
☒ albuterol HFA 90 mcg/act inhaler 2 puff	PRN		Until discontinued
2 puff, inhalation, Every 4 hours PRN, Hypersensitivity reaction, Starting when released, for 1 day			
SHAKE WELL			
☒ acetaminophen (Tylenol) tablet 650 mg	PRN		Until discontinued
650 mg, oral, Once as needed, fever, GREATER THAN or EQUAL TO 38 C, Starting when released, for 1 dose			
For mild/moderate reaction: flushing, rash, pruritus			
☒ diphenhydramine (BENADryl) injection 25 mg	PRN		Until discontinued
25 mg, intravenous, Administer over: 2 Minutes, Once as needed, Hypersensitivity reaction, Starting when released, for 1 dose			
For mild/moderate reaction: flushing, rash, pruritus			
☒ diphenhydramine (BENADryl) injection 50 mg	PRN		Until discontinued

	Interval	Defer Until	Duration
50 mg, intravenous, Administer over: 2 Minutes, Once as needed, Hypersensitivity reaction, Starting when released, for 1 dose For severe reaction: respiratory distress, stridor, wheezing, hypotension (SBP LESS THAN 100 mm Hg)			
☒ hydrocortisone sodium succinate (Solu-CORTEF) injection 100 mg 100 mg, intravenous, Once as needed, Hypersensitivity reaction, Starting when released, for 1 dose For mild/moderate reaction: flushing, rash, pruritus - OR - For severe reaction: respiratory distress, stridor, wheezing, hypotension (SBP LESS THAN 100 mm Hg)	PRN		Until discontinued
☒ EPINEPHrine (EpiPen;Adrenalin) solution 0.3 mg 0.3 mg, intramuscular, Once as needed, Hypersensitivity reaction, Starting when released, for 1 dose For severe reaction: respiratory distress, stridor, wheezing, hypotension (SBP LESS THAN 100 mm Hg)	PRN		Until discontinued

Appointment Requests

☒ Infusion Appointment Request	Every 56 days	Until discontinued
Status: Once, Expected: S, Sched. Duration: 90 minutes, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after		

*Provider signature	Provider printed name	*Date	Time

*Provider phone#

***Denotes field that must be completed by healthcare worker**