

YERVOY™ (ipilimumab)

NURSING IMMUNE-MEDIATED ADVERSE REACTION CHECKLIST



Patient name _____

Date _____

YERVOY (ipilimumab) is indicated for the treatment of unresectable or metastatic melanoma. YERVOY can result in severe and fatal immune-mediated adverse reactions (**please see YERVOY full Prescribing Information for additional information**). The majority of immune-mediated reactions occurred during treatment; however, a few occurred weeks to months after discontinuation of YERVOY. 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 YERVOY 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 YERVOY 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?	Yes	No	
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?			
– 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?			
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	



Bristol-Myers Squibb

©2011 Bristol-Myers Squibb. All rights reserved. 731US11REMS00302 XX/11 Printed in USA.

Please see full Prescribing Information for YERVOY, visit www.YERVOY.com/hcp/rems, or call 1-855-YERVOY1 for more information. This checklist is part of an FDA-approved REMS.