



Dear Healthcare Provider,

(Patient Name): _____

Date of birth: _____

Is currently receiving the following immunotherapy drug(s)

- _____
- _____

This is to notify you that this immunotherapy treatment may increase the patient’s risk of experiencing the following immune related adverse events:

- Dermatitis
- Diarrhea/colitis
- Hepatitis
- Pneumonitis
- Nephritis
- Endocrinopathies including hyper or hypothyroidism, adrenal insufficiency or diabetes (including diabetic ketoacidosis)
- Other toxicities including: cardiac, ocular, hematological, myopathies and neurological (including paresis, Guillian-Barré and encephalitis)

These adverse events can be life-threatening and require specific management. Coordination with the prescriber is required.

If the patient experiences any of these symptoms or if you need more information, please contact:

Prescriber’s name: _____

Phone number (office): _____

Phone number (after hours): _____