[Clinic or Hospital Logo]		
	SOP #	[Number]
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Telephone Triage of Patients Undergoing Bispecific T-Cell Engager Therapy

Where Did This Resource Come From?	
Clinic/Hospital Type	Mid-sized, community-based clinic
What's Unique?	• Integrates remote vital sign assessment and symptom-based triage to guide timely office visits, ED referral, and coordination with the infusion team

1. Purpose

To establish a standardized procedure for the telephone triage of patients receiving bispecific T-cell engager (BTCE) therapy, ensuring timely assessment, intervention, and escalation to prevent complications such as Cytokine Release Syndrome (CRS) and Immune Effector Cell-Associated Neurotoxicity Syndrome (ICANS).

2. Scope

This policy applies to all clinical and administrative staff involved in the telephone triage of patients undergoing BTCE therapy.

3. Definitions

- **Bispecific T-Cell Engager (BTCE):** Synthetic proteins that bind two distinct antigens: one targets the CD3 protein on T cells, and the other targets a specific cancer antigen, redirecting T cells to activate an antitumor immune response.
- **Cytokine Release Syndrome (CRS):** A potentially severe inflammatory response triggered by immune effector cell therapy that causes cytokines to be released into the bloodstream. Symptoms include fever, hypotension, hypoxia, chills, tachycardia, dyspnea, nausea, rash, headache, and myalgia.
- **Immune Effector Cell-Associated Neurotoxicity Syndrome (ICANS):** A neurological complication resulting from inflammation in the central nervous system following immune effector cell therapy. Symptoms can range from mild (e.g., headache, confusion) to severe (e.g., seizures, coma), potentially life-threatening.

4. Responsibilities

- **Triage Staff:** Conduct structured assessments and quickly escalate concerns.
- **Clinical Providers:** Evaluate and manage patients with concerning symptoms.
- **Infusion Team:** Administer urgent hydration and appropriate treatments for at-risk patients.

5. Procedure

- **Initial Patient Assessment:**
  - Ensure the patient has a blood pressure cuff, thermometer, and pulse oximeter available at home.
  - Instruct the patient to measure and report their vital signs during the phone assessment.

- **Assessment Questions:**
  - Is the patient experiencing a fever (Temperature ≥100.4°F) or chills?
  - Is the patient reporting dizziness, shortness of breath, racing heart, restlessness, headache, confusion, difficulty speaking, seizures, tremors, or muscle weakness?
  - Does the patient have any challenges with naming objects, following commands, language/writing, attention, or orientation (i.e., awareness of the current year, month, city, hospital)?

- **Patient Details Documentation:**
  - Record the onset, location, duration, characteristics, associated factors, relieving factors, and any treatments tried.

- **Triage Recommendations:**
  - Schedule a same-day office appointment if any of the following criteria are met:
    - Temperature ≥100.4°F (38°C)
    - Pulse oximetry ≤90% or a drop greater than 5% from baseline
    - Blood pressure dropping more than 10 points (systolic or diastolic) from baseline or BP <90/70 mmHg
    - Resting heart rate >110 BPM
    - Any neurological symptoms (e.g., confusion, memory loss, seizures, slowed speech, headache, new/mild tremors, muscle weakness)
    - New rash, especially if associated with fever
  - Advise the patient to go to the Emergency Department if any of the following occur:
    - The patient cannot be awakened by voice
    - The patient has a seizure
    - The patient experiences hypotension resulting in syncope
    - Symptoms such as chest discomfort, heart palpitations, or new/worsening shortness of breath or respiratory distress

- **Action Plan:**
    - If any concerning symptoms are reported, contact the APP team immediately instead of relying solely on messaging.
    - If the APP is unavailable, inform the attending physician and have the patient come to the office without delay.
    - Coordinate with the infusion nurse in charge to arrange urgent hydration and clinic evaluation.
    - Notify designated internal staff via email about the patient's urgent condition.

- **Lab Orders:**
    - Complete the following lab tests:
        - CBC, CMP, Magnesium, Phosphorus, Uric Acid, LDH, CRP, Ferritin
        - Blood cultures x2 if febrile (Temperature ≥100.4°F)

- **Follow-Up and Documentation:**
    - Encourage the patient with a same-day appointment to arrive as soon as possible.
    - Document all assessments, interventions, and communications in the Electronic Health Record (EHR).
    - If the recommended steps cannot be fully completed, consult clinic leadership for further guidance.

6. Safety and Compliance Considerations

- Adhere to established guidelines for emergency triage and escalation.
- Ensure accurate and thorough documentation in the EHR.
- Maintain effective communication with clinical teams to expedite patient care.

7. Revision History

Version #	Date	Description of Changes	Reviewed / Approved By