Alberta QuantiFERON Guidelines for Testing for Latent Tuberculosis Infection

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Alberta QuantiFERON Guidelines for Testing for Latent Tuberculosis Infection

Section 1 – Introduction

1.1 Purpose of the Guidelines

The purpose of these guidelines is to provide a framework for the appropriate use of QuantiFERON (QFT) testing in the detection of latent Tuberculosis infection (LTBI) prior to the initiation of potent immunosuppression and/or biological immunomodulatory therapies within Alberta's healthcare system.
These guidelines aim to address the significant variation in current QFT ordering practices, improve clinical appropriateness, and enhance patient outcomes through more targeted testing. These guidelines are intended to support clinicians across specialty areas in determining when QFT testing is indicated, thereby supporting consistent and evidence-aligned ordering practices.
By establishing standardized criteria for QFT ordering and utilization, these guidelines support:

- Consistent application of QFT testing across clinical specialties and geographic zones based on evidence.
- Clinical appropriateness criteria for ordering QFT testing for LTBI in the context of patients requiring potent immunosuppression and/or biological immunomodulatory therapies.
- Clinical clarity for providers managing patients at risk for Tuberculosis (TB) reactivation, particularly in the context of patients requiring potent immunosuppression and/or biological immunomodulatory therapies.
- Reduced test duplication, delays in therapy initiation, and inappropriate screening.
- Alignment of QFT ordering practices across Alberta.

These guidelines are not intended to:

- Provide guidance on ordering QFT outside of patients being initiated on or treated with potent immunosuppression and/or biological immunomodulatory therapies.

  Please refer to TB Services or Infectious Diseases for guidance on QFT testing and appropriate screening for LTBI in other patient populations (e.g., refugees/new immigrants, outbreak testing).

1.2 Background

QuantiFERON (QFT), an interferon-gamma release assay (IGRA), is a laboratory-based blood test used to identify latent Tuberculosis infection (LTBI) by measuring immune reactivity to *Mycobacterium tuberculosis* antigens. In Canada, there are currently two IGRAs available to test for LTBI: the QuantiFERON-TB Gold Plus (QFT-Plus) assay and the T-SPOT.TB assay. As both IGRAs are acceptable for use, and the decision on which test to adopt lies with individual provinces, Alberta utilizes the QFT-Gold In-Tube PLUS IGRA. Therefore, for the purposes of these guidelines, when referring to QFT testing in Alberta, it can be assumed that the IGRA referenced is the QFT-Plus assay. Since its adoption in Alberta in 2005, QFT testing has increasingly been used as an alternative to the tuberculin skin test (TST), especially in immunocompromised populations or those with prior Bacille Calmette-Guérin (BCG) vaccination. Both QFT and TST testing face access challenges, including variability in local service availability, geographic inequities, and logistical barriers that may limit timely or consistent patient access across Alberta. Therefore, it is recognized that either QFT or TST may be utilized for the purpose of screening for LTBI prior to initiation of potent immunosuppression and/or biological immunomodulatory therapies as outlined in this guideline.

Despite its clinical value, there are currently no provincial guidelines for QFT utilization. There is currently significant variation in QFT test ordering and utilization across clinical specialties and between north and south sectors of Alberta. In addition, there has been variation in how clinical programs have embedded QFT testing into pre-treatment screening practices leading to some programs routinely ordered QFT while others have yet to adopt its regular use prior to initiating patients on potent immunosuppression and/or biological immunomodulatory therapies. This variability has created inequities in access to QFT testing, potential gaps in patient safety, and inefficient resource use. These guidelines are designed to ensure that QFT is used when and where it provides the most clinical value: in patients with increased risk of TB reactivation post treatment with potent immunosuppression and/or biological immunomodulatory therapies, and those in whom diagnosis and treatment of LTBI would meaningfully alter outcomes. Key factors to consider:

- QFT is a blood-based interferon-gamma release assay (IGRA) used for latent Tuberculosis infection (LTBI) detection.
- QFT has higher specificity than TST, particularly in BCG-vaccinated individuals in detecting LTBI; the sensitivity of both tests may be reduced in severe immunosuppression.

- Significant ordering variation and utilization of QFT currently exists across zones/corridors and specialties within Alberta.

Section 2 – General Indications and Contraindications for QFT Testing Prior to the Initiation of Potent Immunosuppression and/or Biological Immunomodulatory Therapies

2.1 When to Prefer QFT Over TST

QFT can be ordered by medical specialists for the specific purpose of screening patients for LTBI prior to the initiation of potent immunosuppressant and/or biological immunomodulatory therapies.

QFT is the preferred test for LTBI screening for this purpose in the following scenarios:

- **Patients on or Anticipated Starting Potent Immunosuppressant and/or Biological Immunomodulatory Therapies**
    - Patients currently on or initiating:
        - Specific immunosuppressive and/or biological therapies (e.g., anti-TNF inhibitors, JAK inhibitors) and other potent immunosuppressants.
        - Prolonged and/or systemic steroids (e.g., bioequivalent of 15mg/day of prednisone for more than one month) or when cumulative immunosuppression is high.
        - Some chemotherapy, particularly for treatment of lymphoma, leukemia, head and neck cancer or lung cancer. Specialists can determine specific risks of chemotherapy and LTBI screening requirements.
        - Transplant (organ or cellular).
        - End stage renal disease requiring dialysis.

    - **Rationale:**
        - QFT has shown high sensitivity.
        - Avoid discordant dual testing results for patients with medical comorbidities.
        - Patients requiring potent immunosuppression may be on multiple medications or have medical comorbidities that make preventative

TB therapy challenging thus increasing the value of accurate diagnosis of LTBI prior to initiating therapy.
        - LTBI screening requirements may be outlined by specific drug recommendations.
- **Barriers to TST Follow-up**
    - Patients with:
        - Transportation or mobility challenges where two visits could lead to loss of follow-up to TB testing.
        - Socioeconomic instability and resulting adherence challenges.
        - Access barriers to TST testing or result interpretation (e.g., unable to return for follow-up appointment).
    - **Rationale:**
        - QFT requires only one visit to draw required blood work and results are reported within the patient's record.
        - TST requires two visits by the patient: one to administer tuberculin injection and a second 48-72 hours later for follow-up and interpretation of results.
        - It is acknowledged that QFT blood draw can only occur in designated centers, usually in cities or major towns; thus, for some people, the QFT may actually be harder to access than the TST.
- **History of Bacille Calmette-Guérin (BCG) Vaccination**
    - Especially if:
        - BCG vaccine was administered after infancy (> 1 year of age).
        - Multiple BCG doses were received.
        - Uncertain of BCG vaccination history.
    - **Rationale:**
        - Unlike TST, QFT is unaffected by BCG vaccine, avoiding false positives that are common with TST.
- **TST is Impractical or Unreliable**
    - Examples:
        - Severe dermatologic conditions that may impact result interpretation.
        - Older adults due to potential changes in skin turgor and age-associated immune function.
        - Known anergy.
        - Prior adverse reactions to TST.
        - History of positive TST with no treatment.
    - **Rationale:**
        - QFT is a lab-based test and therefore more practical in these contexts.

- **Need for Rapid Result Turnaround**
  - When clinical decisions must be made quickly prior to initiation of potent immunosuppressant and/or biological immunomodulatory therapies.
  - **Rationale:**
    - QFT results are typically available within 24-48 hours compared to TST which requires 48-72 hours for result interpretation.
    - QFT results are reported directly into patient records.

2.2 When to Avoid or Defer QFT

QFT should not be ordered reflexively. Avoid or defer QFT testing in the following situations:

- **Diagnosis or Suspicion of Active TB**
  - QFT itself cannot establish or exclude a diagnosis of active TB.
  - **Rationale:**
    - If active TB is suspected, consult with a TB, Infectious Diseases or Pulmonology specialist to guide appropriate testing.
- **Previously Treated for TB Infection or Disease**
- **Documented Prior Positive QFT**
  - **Rationale:**
    - A positive QFT is anticipated to be positive for life, therefore repeat testing is not recommended.
    - A positive QFT requires referral to TB Services
      - Refer to the link below for the Tuberculosis (TB) Provincial Referral Process.
        - 07.330 TB Provincial Referral Process
      - *Please note this document refers to patients with a positive TST but also includes patients with a positive QFT.
- **Low-Risk, Low-Prevalence Settings**
  - Asymptomatic patients without TB risk factors or planned immunosuppression.
  - **Rationale:**
    - Routine screening is not supported by evidence and may lead to unnecessary interventions.
- **Previously Negative QFT**
  - Unless:
    - Prior result was indeterminate.
      - Refer to section *4.3 QFT Indeterminant*

- Patient has new TB exposure warranting repeated QFT, as evidenced by:
  - Patient has documented close contact with known person with active TB.
  - Travel to regions with high TB incidence, specifically:
    - ≥1 month of travel with very high-risk contact, particularly direct patient contact in a hospital or indoor setting, but possibly including work in prisons, homeless shelters, refugee camps
    - ≥3 months of travel to TB incidence country >400/100,000 population**
    - ≥6 months of travel to TB incidence country 200-399/100,000 population
    - ≥12 months of travel to TB incidence country 100-199/100,000 population
  - * Information sourced from *Table 4: Recommendations of the Canadian Thoracic Society for groups for targeted LTBI screening* (p. 334) from the Canadian Tuberculosis Standards 7th edition, Chapter 13. https://cts-sct.ca/wp-content/uploads/2018/01/Canadian-Tuberculosis-Standards_7th-edition_Complete.pdf

- **Rationale:**
  - Generalized repeat testing offers limited value and wastes resources.
  - Repeat QFT is not indicated with change in immunosuppression, unless the patient has new TB exposure as outlined above.

- **Patients Not Being Considered for Potent Immunosuppression and/or Biological Immunomodulatory Therapies and Without Clinical Indication**
  - These guidelines are not intended to provide guidance on ordering QFT outside of patients being initiated on or treated with potent immunosuppression or biological immunomodulatory therapies.
  - Refer to TB Services or Infectious Diseases for guidance on QFT testing and appropriate screening for LTBI in other patient populations (e.g., refugees/new immigrants, outbreak testing).
  - **Rationale:**
    - QFT may not be the most appropriate test in other circumstances and carries additional costs without additional benefit.

2.3 When TST is Preferred

There are certain circumstances when QFT is not recommended and TST is indicated as the preferred test to screen for LTBI.

- **Complete TST as the Preferred Test in the Following Scenarios:**
  - Access barriers to QFT testing.
  - Children under 18 months of age.
  - When serial testing is required (e.g. occupational screening for some health care workers).

2.4 Rescreening and/or Repeat QFT Testing

Repeat QFT testing is generally unnecessary. There may be specific situations when rescreening, repeat and/or serial QFT may be appropriate.

- **Avoid Retesting, Unless:**
  - **Repeat exposure**
    - For example, documented repeat contact or prolonged residence/travel to TB endemic country.
  - **QFT result is indeterminate** (see section *4.3 QFT Indeterminate*)
    - May repeat QFT once in 2-4 weeks' time.
    - Seek consultation from TB Services or Infectious Diseases.
- **Annual QFT Testing Is Not Routinely Recommended**
  - However, annual QFTs may be considered in certain patients on long-term biological immunomodulatory therapies or targeted immunosuppressant who have been re-exposed to TB (confirmed contact) or those who have prolonged travel to high-incidence communities.
  - For certain populations where serial or annual testing may be indicated (e.g., occupational screening for some health care workers) TST is the preferred test

  * For additional information refer to *Table 4: Recommendations of the Canadian Thoracic Society for groups for targeted LTBI screening* (p. 334) from the Canadian Tuberculosis Standards 7th edition, Chapter 13. https://cts-sct.ca/wp-content/uploads/2018/01/Canadian-Tuberculosis-Standards_7th-edition_Complete.pdf

Section 3 – Ordering and Collection of QFT

3.1 Specific Considerations for Ordering QFT

- **Appropriate Ordering Specialties**
  - Ordering QFT should be restricted to TB Services, Infectious Diseases, and clinical specialists who initiate potent immunosuppressant and/or biological immunomodulatory therapies.
  - Outside of these specialty areas, please consult TB Services for guidance and clarity on when to appropriately order QFT and for which patients.
  - For additional information related to ordering QFT please refer to Alberta Precision Laboratories (APL) Test Resource: QuantiFERON TB Testing
- **Timing and Logistics**
  - Clinicians are encouraged to order QFT at the time of immunosuppression and/or biological immunomodulatory therapy planning, ideally within six months **prior to drug initiation**.
  - A previously documented positive QFT or TST result may be sufficient.
  - **Rationale:**
    - QFT should be ordered appropriately within treatment planning window, ideally ≤12 months before anticipated start, to avoid access delays.
- **Additional Screening Considerations**
  - Chest x-ray may be considered based on patient history and risk-factors and in cases of positive QFT or if patient is symptomatic for TB.

3.2 Specific Considerations for Collection of QFT

There are specific collection requirements and collection sites that need to be considered when collecting blood samples for QFT testing.

- Please refer to Alberta Precision Laboratories (APL) Test Directory for guidance on QFT collection, processing, and list of limited collection sites.
  Alberta Precision Laboratories | Lab Services - QuantiFERON-TB Gold Plus
  - Specific Considerations:
    - Adherence to proper collection procedure.
    - Ensure use of appropriate collection tubes.
      - Due to requirement for specific collection tubes QFT cannot be added on to previously drawn bloodwork.
    - Awareness of restricted collection sites.

It is important to ensure collection of QFT is done correctly. The collection procedure needs to be strictly followed to prevent sample rejection and to minimize indeterminate results that would necessitate repeat testing.

Section 4 – Interpretation of Results and Next Steps

4.1 QFT Positive

- Refer to TB Services for guidance on further assessment, diagnosis, and considerations for preventative therapy.
    - Patients with a positive QFT will require a 2-view chest x-ray (PA & lateral) as well as a completed TB referral.
        - For the Tuberculosis (TB) Provincial Referral Process see 07.330 TB Provincial Referral Process
    - *Please note this document refers to patients with a positive TST but also includes patients with a positive QFT.
        - **Note:** Organ transplant candidates (other than Calgary zone) are referred to transplant ID.
            - For additional information please refer to:
                - Transplant Infectious Diseases | Insite
                - *Clinical Practice Guideline: Donation and Transplantation Tuberculosis Screening and Management Guidance* (Implementation Date June 2025)

4.2 QFT Negative

- Proceed with immunosuppressants or biological therapies, provided active disease is not suspected.

4.3 QFT Indeterminant

- May repeat QFT once in 2-4 weeks' time.
- If repeated tests remain indeterminate, consider consulting TB Services.

Appendices

Appendix A

Specialty Specific Indications for QFT Testing

The following section outlines clinical indications for QFT use across key specialties in Alberta. These recommendations are based on expert consultations and reflect current evidence-informed practices, zone-specific protocols, and the need for consistent provincial guidance.

- **Program-level protocols:** Follow zone/corridor/program workflows as applicable for the intended purpose of screening for LTBI prior to the initiation of potent immunosuppression and/or biological immunomodulatory therapies.

NOTE: These guidelines indicate current practice, medications listed are not a comprehensive list and serve as examples only and may change over time, screening is indicated but not limited to these agents.

Rheumatology

QFT is strongly recommended prior to the initiation of biologic disease-modifying antirheumatic drugs. Given the increased risk of TB reactivation associated with these agents, identifying and treating latent TB is a critical safety consideration.

- **Screening Indications:**
  - Before initiating biologic, targeted synthetic or conventional synthetic DMARDs (b/ts/csDMARDs), including:
    - TNF inhibitors (e.g., infliximab, adalimumab).
    - JAK inhibitors (e.g., tofacitinib, baricitinib).
    - IL-6/IL-17 inhibitors (e.g., tocilizumab, secukinumab).
    - Abatacept (CRA Level IV recommendation).
    - B-cell depletion therapies (e.g., rituximab, belimumab).
    - Anti-interferon receptor 1 antagonists (e.g., anifrolumab).
  - Before initiating other immunosuppressants or glucosteroids
    - Particularly: Prednisone or bioequivalent of 15mg/day of prednisone for more than one month is planned.

Gastroenterology

QFT should be part of the pre-treatment workup for patients with inflammatory bowel disease (IBD), including Crohn's disease, ulcerative colitis (UC), and inflammatory bowel disease unclassified (IBD-U), who are being considered for anti-TNF agents, JAK inhibitors, or other biologics and advanced therapies.
Timely ordering of QFT supports access to therapy and avoids treatment delays due to pending TB screening results. The test should be ordered once the decision to initiate immunosuppressive therapy is made but before biologic access requests are submitted. Ensure QFT resulted before drug access requests.

- **Screening Indications:**
  - Pre-workup for anti-TNF, JAK inhibitors, and other biologics and advanced therapies in inflammatory bowel disease.

Dermatology

Patients with moderate-severe psoriasis, atopic dermatitis, and other inflammatory dermatoses who are candidates for systemic or biologic/targeted therapies have increased risk of LTBI reactivation. Certain biologic agents, particularly TNF inhibitors and IL-12/23 inhibitors, are associated with increased risk of TB reactivation due to their immunosuppressive mechanisms. Screening helps mitigate this risk and guides appropriate treatment decisions.
QFT is indicated prior to starting systemic immunosuppressants such as methotrexate, cyclosporine, or biologics including anti-TNF, JAK inhibitors, or IL-17 agents. It is not routinely required for patients on lower-risk agents such as dupilumab unless additional TB risk factors are present (e.g., previous exposure, endemic country of origin).

- **Screening Indications:**
  - Before systemic immunosuppressants (e.g., cyclosporine, azathioprine, mycophenolate, methotrexate).
  - Prior to TNF- α inhibitors (adalimumab, infliximab, etanercept, certolizumab).
  - Prior to other biologic/targeted therapies (e.g., IL-12/23, IL-17, IL-23, PDE4, TYK-2, JAK inhibitors).
  - Prior to initiation of oral corticosteroids (especially ≥20 mg prednisone-equivalent for > 2 weeks) in higher-prevalence settings or if additional TB risk factors exist.
- **Not Required**

- Initiation of topical therapies and phototherapy alone (no evidence of TB reactivation).
- Lower-risk biologics such as dupilumab.

Nephrology / Alberta Kidney Care (AKC)

QFT is routinely used by Alberta Kidney Care for all new dialysis patients, kidney transplant candidates, and patients starting immunosuppressive therapy for glomerulonephritis (GN). This practice reflects the higher TB risk associated with chronic kidney disease and transplant immunosuppression. Where prior QFT results exist, repeat testing should only be done if the patient's exposure risk or immunological status has changed significantly and previous test was negative or indeterminate.

- **Screening Indications:**
  - All new dialysis patients, kidney transplant candidates, and GN pre-immunosuppression.

Solid Organ Transplant (SOT)

QFT is required for all transplant recipients as part of pre-transplant infectious disease screening.
Living donors at increased TB risk (e.g., from endemic regions or known exposure) should also undergo QFT testing.
For additional information please refer to:

- Clinical Practice Guideline: *Donation and Transplantation Tuberculosis Screening and Management Guidance* (Implementation Date June 2025) available via Transplant Infectious Diseases | Insite

Bone Marrow Transplant (BMT) / CAR-T

Patients undergoing Car-T therapy or Bone Marrow Transplant (BMT), either allogenic or autologous, should have documented QFT screening prior to conditioning therapy. TB reactivation in these highly immunosuppressed populations carries significant risk of morbidity.
QFT should be performed only once prior to treatment unless the result is indeterminate or there is new clinical concern
.

- **Screening Indications:**
  - All CAR-T, allogeneic, and autologous transplant candidates pre-conditioning.
  - Prior to initiation of selected biologics (e.g., rituximab, daratumumab) per program.

Oncology / Hematology

In oncology/hematology, QFT may be considered for patients receiving intensive/potent immunosuppression, monoclonal antibodies, and/or bispecific antibodies. It is not routinely indicated for solid tumor patients unless risk factors for TB exposure are identified.

- **Screening Indications:**
  - Patients receiving:
    - Potent immunosuppression (e.g., stem cell transplant conditioning, prolonged high-dose steroids).
    - Monoclonal antibodies (e.g., rituximab, obinutuzumab, daratumumab, blinotumomab, etc.).
    - Bispecific antibodies.
- **Not Required**
  - Solid tumor oncology unless protocolized or risk factors identified.

Ophthalmology

QFT is appropriate in patients with ocular disease who require potent systemic immunosuppression treatment or with patients with systemic autoimmune disease. In select cases of uveitis, where ocular TB is suspected to be the cause, QFT can be helpful in diagnostic evaluation.

- **Screening Indications:**
  - Uveitis where ocular TB is suspected.
  - Prolonged systemic steroids or other immunosuppressants are planned for treatment of non-TB related uveitis.

- **Not Required**
  - In cases of mild, unilateral uveitis without systemic findings indicative of ocular TB or systemic autoimmune disease.

Neurology

QFT may be considered in patients with neurologic autoimmune conditions for which immunosuppressive therapy is being initiated (e.g., multiple sclerosis, autoimmune encephalitis, neurosarcoidosis).
Routine screening in low-risk multiple sclerosis (MS) patients is not recommended unless high-dose or long-term immunosuppression is planned. Clarification through program-specific guidance is recommended.

- **Screening Indications:**
  - Prior to immunotherapy for MS, autoimmune encephalitis, neurosarcoidosis, or neuromuscular syndromes when high-dose/long-term immunosuppression is planned.
- **Not Required**
  - In low-risk MS where minimal immunosuppression is planned.

Infectious Diseases (e.g., HIV)

QFT should be ordered for all people with HIV to evaluate for LTBI due to risk of reactivation of TB with immunosuppression.

- **Screening Indications:**
  - All people with HIV should be screened for LTBI.
  - All people with HIV with new/repeated TB exposure or travel to TB endemic areas, as long as there is no prior history of positive and/or treated TB infection/disease. If there is history of prior TB, referral to TB services as appropriate.

Appendix B

Patients Who May be Considered At Risk for LTBI or for New TB Exposure

Groups with increased risk of TB exposure and latent TB infection include:

- Close contacts of a person with of pulmonary TB.
- Immigrants from countries with high incidence.
- Injection drug users.
- Homeless.
- Aboriginal communities.
- Health care workers.
- Residents of long-term care facilities.
- Residents of correctional facilities.
- Travelers to countries with high TB incidence.

For additional information on potential high-risk populations please refer to the Canadian Tuberculosis Standards 7th Edition, Chapter 13: Tuberculosis Surveillance and Screening in Selected High-Risk Populations
https://cts-sct.ca/wp-content/uploads/2018/01/Canadian-Tuberculosis-Standards_7th-edition_Complete.pdf

Appendix C

Potent Immunosuppressant Medications and Biological Immunomodulatory Therapies That May Indicate Need for LTBI Screening Prior to Initiation

The following immunosuppressant and biological therapies represent a list of medications that may indicate the need to screen for LTBI prior to their initiation. Screening is indicated but not limited to these agents.

This is ***not a comprehensive list*** and serves only as an example. *It is recognized that these medications and therapies may change over time.*

- Systemic immunosuppressants (e.g., cyclosporine, azathioprine, mycophenolate, transplant conditioning agents).
- Biologic, targeted synthetic or conventional synthetic DMARDs (b/ts/csDMARDs), including:
  - TNF- α inhibitors (e.g., infliximab, adalimumab, etanercept, certolizumab)
  - JAK inhibitors (e.g., tofacitinib, baricitinib)
  - IL-6/IL-17 inhibitors (e.g., tocilizumab, secukinumab)
  - Abatacept (CRA Level IV recommendation)
  - B-cell depletion therapies (e.g., rituximab, belimumab)
  - Anti-interferon receptor 1 antagonists (e.g., anifrolumab)
- Other biologic/targeted therapies (e.g., IL-12/23, IL-17, IL-23, PDE4, TYK-2).
- Monoclonal antibodies (e.g., rituximab, obinutuzumab, daratumumab, blinotumomab) and bispecific antibodies.
- Oral glucosteroids or corticosteroids (e.g., bioequivalent of 15mg/day of prednisone for more than one month in higher-prevalence settings or if additional risk of TB exposure exist).

Appendix D

QFT Testing Decision Algorithm

1. **Is the patient starting on potent immunosuppressive and/or biological immunomodulatory therapy and/or at an increased risk for reactivation of LTBI due to immunosuppression?**
   Including, but not limited to anti-TNF inhibitors, JAK inhibitors, IL-17/23/12-23 inhibitors, cyclosporine, mycophenolate, B-cell depletion therapies, high-dose prednisone (e.g., bioequivalent of 15mg/day of prednisone for more than one month), transplant immunosuppression, dialysis, history of HIV, etc. For additional information, please refer to the *Alberta QuantiFERON Guidelines for Testing for Latent Tuberculosis Infection.*
   - **Yes** – Proceed to Step 2
   - **No** – Do not order QFT unless other specialty-approved indications exist
     - These guidelines do not address screening outside potent immunosuppression and/or biological immunomodulatory therapy

2. **Does the patient have TB symptoms or abnormal chest imaging?**
   (cough > 3 weeks, fevers, night sweats, weight loss; CXR cavitation, infiltrates, nodules)
   - **Yes** – Suspect active TB
     - Do not order QFT
     - Urgent referral/consult to TB services or Infectious diseases for diagnostic workup
   - **No** – Proceed to Step 3

3. **Has the patient ever had a positive QFT or TST?**
   - **Yes** – Previously positive
     - Do not repeat QFT/TST
     - Assess for symptoms; rule out active TB if indicated
     - If asymptomatic and not previously treated with preventative TB therapy, refer to TB services prior to initiating immunosuppressive therapies
   - **No** – Proceed to Step 4

4. **Is QFT the preferred test in this patient?**

QFT is preferred when:

- Planned potent immunosuppression and/or biological immunomodulatory therapy in next 6-12 months
- BCG vaccinated or uncertain BCG history
- Technical barriers to TST testing (e.g., severe skin disease)
- Access barriers to TST testing/result interpretation (e.g., unable to return for follow-up)
- Rapid testing required for imminent initiation of potent immunosuppression and/or biologic immunomodulatory therapy

- **Yes –** Order QFT
- **No –** Consider TST
    - TST may be appropriate:
        - when there are access barriers to QFT testing
        - In children under 18 months of age

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Guideline Revisions & Version Control

Version	Purpose/Change	Responsible	Date
1.0	Completed and approved guideline	Dr. Greg Tyrrell Dr. Ryan Cooper ACA Clinical Appropriateness Team	26 March 2026