Referral Status:		MRN:	
☐	New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:			

Keytruda® (pembrolizumab) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:				Patient's Phone:			
Patient Name:				Address:			
Date of Birth:				City, State, Zip:			
Height in inches:	Weight:	LB or	KG	Gender:	Allergies:	☐ See list	☐ NDKA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	C43-9 - Melanoma	☐	C67.9 - Urothelial Carcinoma
☐	C34.90 - Non-Small Cell Lung Cancer	☐	C19.9 - Colorectal Carcinoma
☐	C76.0 - Head and Neck Carcinoma	☐	C16.9 - Gastric Carcinoma
☐	C81.90 - Classical Hodgkin Lymphoma	☐	C15.9 - Esophageal Carcinoma
☐	C4A.9 - Merkel Cell Carcinoma	☐	C53.____ - Cervical Carcinoma
☐	C54.1 - Endometrial Carcinoma	☐	C64.____ - Renal Cell Carcinoma
☐	C50.919 - Triple Negative Breast Carcinoma	☐	C44.92 - Cutaneous Squamous Cell Carcinoma
☐	_____Other: _____		

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	Recent CBC
6	

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:

PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:

LAST INJECTION DATE:

NEXT INJECTION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive pembrolizumab if experiencing severe (grade 3) immune-mediate adverse reaction.

MEDICATION:

☑ Keytruda® (pembrolizumab) IV given over 30 minutes diluted in 100mL NS according to FDA labeling.

Premedication:_____

Premedication to be given 30 minutes prior to infusion unless otherwise noted above

DOSE/FREQUENCY:

☐ 200mg every 3 weeks

☐ 400mg every 6 weeks

☐ Other: _____

SPECIAL ORDERS:

☐ _____

Prescriber is responsible for monitoring lab results/abnormalities including pregnancy screening, if applicable. Please ensure timely notification if a hold on therapy is indicated.

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures) DATE:

Dispense as written/Brand medically necessary	Substitution permitted	

Palmetto INFUSION

Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- [ ] **Patient demographics - address, phone number, SS#, etc.**
- [ ] **Insurance information - copy of the card(s) if possible**
- [ ] **Plan of Treatment/Orders**
- [ ] **Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- [ ] **Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com