

Referral Status:		MRN:	
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change	<input type="checkbox"/> 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: <input type="checkbox"/> See list <input type="checkbox"/> NKDA

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

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

REQUESTED DOCUMENTATION: PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INJECTION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INJECTION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE:
5	Recent CBC	THERAPY:	<input type="checkbox"/> Continue current order until insurance approved
6			

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:


<input type="checkbox"/>	200mg every 3 weeks
<input type="checkbox"/>	400mg every 6 weeks
<input type="checkbox"/>	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:

NURSING ORDERS: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

<input checked="" type="checkbox"/> Start PIV/Access CVC <input checked="" type="checkbox"/> Flush device per facility standard flushing procedure <input checked="" type="checkbox"/> Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.	
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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	



Checklist for referrals to Palmetto Infusion: Fax referral to 1.800.521.9640

- 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