

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 2<sup>ND</sup> AND 3<sup>RD</sup> 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:

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	<b>IF ORDER CHANGE:</b>
5	Recent CBC	THERAPY:	
6			<b>Continue current order until insurance approved</b>

### 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:

### NURSING ORDERS:

- Start PIV/Access CVC
- Flush device per facility standard flushing procedure
- Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

### 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