

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:
	See list
	NKDA

### DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> 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: 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	
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:

<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 1.866.872.8920

- 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](http://www.PalmettoInfusion.com)