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|---------------------------------------|---------------------------------------|--|--|
| 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

Rev 4.29.25

PATIENT DEMOGRAPHICS:

| | | | |
|-------------------|---------|-------------------|--|
| Patient Name: | | | |
| Patient's Phone: | | 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:

| | | |
|---|--------------------------------|---|
| 1 | Insurance information | PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE? IF NO: _____ PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY: _____ IF ORDER CHANGE: <input type="checkbox"/> Continue current order until insurance approved |
| 2 | Most recent History & Physical | |
| 3 | Full medication list | |
| 4 | Tried and failed therapies | |
| 5 | Recent CBC | |
| 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:

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.

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 |