Referral Status:		MRN:	
☐	New referral	☐ Order change	☐ 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:	☐ See list	☐ NKDA	

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:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INJECTION DATE:
3	Full medication list		NEXT INJECTION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	Recent CBC		☐ **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:

☐ 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:	ADVERSE REACTION & ANAPHYLAXIS 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	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	

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