Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:			MRN:
	New referral	Order change	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	NDKA

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:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	Recent CBC
6	

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:	IF YES:
PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INJECTION DATE:
	NEXT INJECTION DATE:
	IF ORDER CHANGE:
	☐ **Continue current order until insurance approved**

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:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

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	